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EVALUATION

Mid-Term Performance Evaluation of the USAID/Zambia Integrated Systems Strengthening Program (ZISSP)

[July 2013]

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MID-TERM PERFORMANCE EVALUATION OF THE USAID/ZAMBIA INTEGRATED SYSTEMS STRENGTHENING PROGRAM (ZISSP)

Final Report

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ACKNOWLEDGEMENTS

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ACRONYMS

ACNM	American College of Nurse Midwives
ACT	Artemisinin-based Combination Therapy
AIDS	Acquired Immunodeficiency Syndrome
APAS	Annual Performance Appraisal System
APS	Annual Program Statement
ART	Antiretroviral Therapy
ARV	Antiretroviral
BFHI	Baby Friendly Hospital Initiative
BRITE	Broad Reach Institute of Training and Education
CBHIS	Community-Based Health Information System
BCC	Behavioral Change Communication
CBD	Community Based Distributors (Family Planning)
CBGMP	Community Based Growth Monitoring and Promotion
CCM/iCCM	Clinical Case Management/Integrated Community Case Management
CCM	Community Case Management
CCS	Clinical Care Specialists
CCT	Clinical Care Team
CDC	Centers for Disease Control and Prevention
CEDPA	Centre for Development and Population Activities
CHA	Community Health Assistant
CH	Child Health
CHD	Child Health Days
CHW	Community Health Worker
CO	Clinical Officer
CP	Cooperating Partner
CPR	Contraceptive Prevalence Rate
CSH	Communications Support for Health
DEMS	Direct Entry Midwifery Schools
DHO	District Health Office
DHIO	District Health Information Officer
DHS	Demographic and Health Survey
DMO	District Medical Officer
DQA	Data Quality Audit
EBF	Exclusive Breastfeeding
EGPAF	Elizabeth Glazer Pediatric AIDS Foundation
EHT	Environmental Health Technician
EHO	Environmental Health Officer
EN	Enrolled Nurse
EPI	Expanded Program on Immunization
EmONC	Emergency Obstetric and Newborn Care
ENC	Essential Newborn Care
FANC	Focused Antenatal Care
FP	Family Planning

GIS	Geographical Information System
GPS	Global Positioning System
GRZ	Government of Zambia
GST	Grant Support Team
CSO	Central Statistical Office
HCAC	Health Center Advisory Committee
HCM	Human Capital Management
HF	Health Facility
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resources
HRH	Human Resources for Health
HRM	Human Resource Management
HRIS	Human Resources Information System
HSSP	Health Services and Systems Program
HW	Health Worker
iCCM	Integrated Community Case Management
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Preventive Therapy
IRS	Indoor Residual Spraying
IUD	Intrauterine Device
IYCF	Infant and Young Child Feeding
JHUCCP	Johns Hopkins University Center for Communication Programs
LC	Lay Counselors
LLIN	Long Lasting Insecticidal Net
MCDMCH	Ministry of Community Development/Mother and Child Health
MDG	Millennium Development Goals
MIS	Malaria Indicator Survey
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MOP	Malaria Operational Plan
MOU	Memorandum of Understanding
MNCH	Maternal Newborn and Child Health
MS	Management Specialist
MSL	Medical Stores Limited
MW	Midwife
NHC	Neighborhood Health Committee
NHSP	National Health Strategic Plan
NIPA	National Institute for Public Administration
NMCC	National Malaria Control Centre
NFNC	National Food and Nutrition Commission
PA	Performance Assessment
PHO	Provincial Health Office
PMEC	Payroll Management Establishment Control
PMEP	Performance Monitoring and Evaluation Plan

PMI	President's Malaria Initiative
PMP	Performance Management Package
PMTCT	Prevention-of-Mother-to-Child Transmission (of HIV)
PPAZ	Planned Parenthood Association of Zambia
PPP	Public-Private Partnership
PSMD	Public Service Management Division
QI	Quality Improvement
RED	Reach Every Child in Every District
RFA	Request for Applications
RH	Reproductive Health
SHARe	Support to the HIV/AIDS Response
SMAG	Safe Motherhood Action Group
SMGL	Saving Mothers, Giving Life Initiative
SOW	Statement of Work
TSS	Technical Support Supervision
USAID	United States Agency for International Development
WHO	World Health Organization
WISN	Workload Indicators for Staffing Needs
ZHWRS	Zambia Health Worker Retention Scheme
ZISSP	Zambia Integrated Systems Strengthening Program
ZMLA	Zambian Management and Leadership Academy
ZPCT II	Zambia Prevention Care and Treatment Partnership II

EXECUTIVE SUMMARY

This is a report on the mid-term evaluation of the Zambia Integrated System Strengthening Program (ZISSP) funded by the United States Agency for International Development (USAID) Mission in Zambia. The evaluation was conducted during the period March – July, 2013, by a team assembled by Mendez, England & Associates (ME&A) with headquarters in Bethesda, Maryland. The team consisted of two international and three local experts – all with experience in evaluating and/or working on health projects in Africa.

EVALUATION PURPOSE AND EVALUATION QUESTIONS

The purpose of the mid-term evaluation was to assess ZISSP's progress towards meeting its goals and objectives from three perspectives and make recommendations related to three evaluation objectives:

- **Objective A - (Retrospective):** Progress made toward achieving project objectives - from ZISSP's Scope of Work (SOW) - including Project Design (Conceptual Framework) in light of implementation experience and lessons learned to date.
- **Objectives Part B - (Prospective):** Based on the findings from Objective A, recommendations for ZISSP's project implementation through 2014, including optimal mix of activities and funding for achieving project objectives; sustainability taking into account the current: (i) Zambian Government (GRZ) structure that involves two ministries dealing with health;(ii) Zambian health policies; (iii) U.S. Government (USG) policies;
- **Objectives Part C:** Using above findings (Objective A and B) frame issues to debate/discuss/resolve at a level higher than the project, e.g. at the level of the GRZ and/or other donor organizations.

The evaluation was an assessment of progress and not intended to infer causal linkages between project interventions and outcomes/results, measure impact, or assess attribution.

PROJECT BACKGROUND

ZISSP is a 4.5 year project that began in June 2010 and will end on December 14, 2014, with activities focused at the national, provincial, district and community levels. According to ZISSP's results framework, the program's goal is to increase the utilization of high-impact health services through a health systems strengthening (HSS) approach, based on the World Health Organization (WHO) "building blocks" definition[1] to target improved Maternal, Child and Newborn Health (MNCH), Family Planning, HIV/AIDs, Malaria, and Nutrition Services. The rationale for the project was the assessment conducted by the Zambian Ministry of Health (MOH)[2], which determined that the most effective key health interventions needed to meet the Millennium Development Goals (MDGs) were hindered by multiple health system weaknesses. These weaknesses affected information and services targeting women of reproductive age, their partners, children under 5 years of age, people living with HIV/AIDS, and their families and communities for health service delivery at the heath facility, community and household level.

ZISSP works in 9 provinces[3] and 27 districts[4]. Its goal is to increase utilization of critical high-impact services and foster sustained improvements in management of the health system. The project uses five main strategies: 1) employing a whole-system approach to unblock obstacles and strengthen the delivery and utilization of essential services; 2) building Zambian capacity as the foundation for sustainability; 3) increasing impact through partner engagement and integration; 4) planning from the "bottom-up" to ensure relevance and participation; and 5) ensuring gender integration[5].

ZISSP is implemented by Abt Associates. Subcontractors include the American College of Nurse Midwives (ACNM), AKROS, Johns Hopkins University Center for Communication Programs (JHUCCP), The Liverpool School of Hygiene and Tropical Medicine, Planned Parenthood Association of Zambia (PPAZ), and BroadReach Institute for Training and Education (BRITE). Banyan Global was an original partner for public-private partnerships (PPP) but their activities were not implemented because USAID decided to fund PPPs through another project.

ZISSP is organized into four tasks: 1) strengthened ability of the MOH (now including the Ministry of Health and the Ministry of Community Development/Maternal and Child Health (MCDMCH)) at the national

[1] WHO, Monitoring and Evaluating Health Systems Strengthening Programs, 2010.
[2] GRZ National Health Strategic Plan 2011-2015.
[3] A new province was added during the project for a total of ten provinces.
[4] See Annex XII.
[5] ZISSP Task Order, Section C, 2010.

level to plan, manage, supervise and evaluate delivery of health services nationwide; 2) improved management and technical skills in order to increase delivery of quality health services within target districts; 3) improved community involvement in the provision and utilization of health services in target areas; and 4) ensure that service delivery and other activities are effectively integrated at appropriate levels of the health system through joint planning and in-kind activities with appropriate partners. An optional task 5 related to food security was not implemented.

EVALUATION METHODOLOGY

The evaluation used a mixture of quantitative and qualitative evaluation methods that were selected according to the WHO's Operational Framework for Monitoring and Evaluation (M&E) for HSS programs[6]. Quantitative methods included a Likert Survey of GRZ and ZISSP staff opinions related to the evaluations questions, as well as a community health assistant (CHA) survey about supervision. Qualitative methods included extensive document reviews, briefings from ZISSP and partners, and 110 key informant interviews (KIIs) with ZISSP and GRZ counterpart staff at the national, provincial, district and health facility level in 5 provinces and 12 districts[7]. Administrative data reviewed included the Health Management Information System (HMIS), health facility and community health registers, and government pre-service training institution records. The Evaluation Team conducted 3 group interviews with ZISSP's provincial seconded staff, as well as debriefs with USAID, ZISSP and stakeholders. In addition, the team conducted 25 community focus group discussions (FGDs) in project districts. Participants included community health workers (CHWs), CHAs, safe motherhood action groups (SMAGs), neighborhood health committees (NHCs), nutrition volunteers, and health facility clients. A detailed description of the methodology used to answer each evaluation question is included in the Evaluation Matrix in Annex II.

EVALUATION LIMITATIONS

- Administrative data, including ZISSP's approved Project Monitoring and Evaluation Plan (PMEP), consists primarily of output data related to training, and does not include indicators that address most of the capacity building components of the project or provide objective measurements related to several of the evaluation questions. The most recent provincial level data available was from 2011 and, aside from the Malaria Indicator Survey (MIS), the last population-based survey of health indicators at the provincial and national level was conducted in 2007, before the project started.
- Quality of administrative data, especially relevant aspects of the HMIS, is known to be problematic. There are also differences of opinion of how catchment populations are estimated between GRZ's Central Statistical Office and district planners.
- Many GRZ health system functions were in the process of shifting from the MOH to MCDMCH at the time of the evaluation. Some offices and officials could not be located and several MCDMCH managers were not available due to schedule conflicts, travel or illness. The team was able to interview the Clinical Case Management Director of the National Malaria Control Center (NMCC), who was also serving as the NMCC's Acting Director while the Director was out of town; however, most NMCC officials were not available for interviews due to travel or their involvement with the annual visit of the President Malaria Initiative (PMI) team. The PMI position at USAID Zambia was also vacant and not filled until after the evaluation field work was completed[8].

EVALUATION QUESTIONS, FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

What progress has been made in ZISSP's target districts towards improving access to and utilization of Family Planning; HIV/AIDS; MNCH; and Nutrition Information and Services?

ZISSP's mandate is an overall HSS approach intended to improve planning, management and implementation for essential health system functions that have an impact on all targeted technical areas. According to USAID, ZISSP was expected to focus on the HSS elements and technical areas (such as HIV/AIDS), which were supported by the funding and included within the overall HSS components such as planning, mentoring and quality improvement. Technical areas are largely addressed through improving policies, guidelines, protocols and processes in collaboration with GRZ and partners through Technical Working Groups (TWGs) and

[6] WHO, Evaluation of Health Systems Strengthening Programs Operational Framework, 2010.

[7] Provinces were Central, Copperbelt, Eastern, Lusaka and Southern. Districts were Chongwe, Gwembe, Kapiri Mposhi, Luangwa, Luanshya, Lufwanyama, Masaiti, Mkushi, Serenje, Kaloma, Nyimba, Serenje, Sinazongwe

[8] The evaluators were briefed by or interviewed most of the malaria ZISSP-seconded staff at ZISSP HQ and NMCC in Lusaka, and were able to interview GRZ malaria focal persons in Eastern Province and Nyimba district as well as the Acting NMCC Director in Lusaka.

through seconded staff. ZISSP's provincial-level seconded staff provides capacity building in management, planning and mentorship (a method of providing supportive supervision to health staff in provincial and district health offices). ZISSP supports training for large numbers of health workers in health interventions (see Capacity Building). The PMEP is not designed to give full credit to many of the HSS capacity building components of the project; therefore, the evaluators had to rely on lists of activities in project reports, workplans and other documents to identify activities in both systems strengthening and specific technical areas. The evaluators also consulted secondary data sources, such as HMIS, to try to assess whether effects of capacity building could be detected.

Malaria activities in ZISSP are so extensive and varied that evaluators felt the Malaria component could benefit from a more comprehensive separate review, especially since many key NMCC officials were not available to be interviewed. Aside from building capacity of NMCC at the national level, and assisting with epidemiological and insecticide resistance studies, ZISSP is operational in indoor residual spraying (IRS) of insecticides in 20 districts. ZISSP-supported districts exceeded GRZ IRS targets by spraying 86% of structures in their catchment area during the 2012-2013 season[9]. ZISSP also supports the NMCC in insecticide resistance and malaria epidemiology research and surveillance, Geographic Information Systems (GIS), as well as database and M&E tools; however, these activities have no PMEP indicators.

The Likert Survey respondents indicated that progress was being made in the program's technical areas, including malaria. Respondents saw improvements in the health status in target populations but also felt that more needs to be done to achieve national targets. However, evaluators felt that family planning, nutrition, and preventive child health interventions, in particular, need more attention. If they are already addressed in other interventions (e.g. mentoring), they should still be specifically identified in project reports. Evaluators also thought that routine child health services, especially routine preventive services, needed more attention, and that particular consideration should be given to collaboration with other partners working in HSS components outside of ZISSP's mandate.

If USAID would like answers to technical area-specific questions about access and utilization of health services and information, they should provide guidance to ZISSP about how they would like data to be collected and reported. ZISSP should, however, periodically review technical components in its program interventions and ensure that all technical areas are receiving sufficient attention.

What progress has been made to strengthen the capacity of the MOH and NMCC staff at each level (national, provincial, and district) to plan, design, implement, manage, monitor and evaluate health programs within each of the five program areas: 1) HIV/AIDS; 2) Malaria; 3) Family Planning; 4) MNCH; and 5) Nutrition?

ZISSP is primarily a capacity building project; however, capacity building measurements in the PMEP are largely limited to training output indicators. The Likert Survey respondents rated several capacity elements as performing well. The Zambian Management and Leadership Academy (ZMLA) component of the program (implemented by BRITE) and ZISSP's capacity building in support of district annual plans, which incorporates new skills of using performance assessments (PA) for planning and mentorship, are perceived as making significant contributions towards improved national capacity to manage health programs. This was corroborated by KIIs with MOH, Provincial Medical Officers (PMOs), and District Medical Officers (DMOs). ZISSP targeted large numbers of health workers and community volunteers for training in several areas but not all of the technical interventions and training data are included in the PMEP[10]. Training data for some technical areas were combined (e.g. Child Health and Nutrition). Human Resources for Health (HRH) is a large area of project focus, and MOH officials involved in HRH gave ZISSP credit for improving HRH management in several areas.

ZISSP is likely to meet most, if not all, of its training targets; however, capacity building involves more than training because trainees must be able to implement what they have learned. In some areas, follow-up technical supervision and implementation are hindered by reduced district budgets, supply issues, limited human resources, and poor quality data. ZISSP uses the same cascade method of technical training that has been promoted by WHO and other international organizations in Zambia for decades but this method is expensive, takes the limited number of GRZ health officials away from their jobs, and is not considered sustainable. GRZ and ZISSP have taken a step in the right direction by increasing technical training in pre-service institutions, developing management leadership training[11], and encouraging DMOs to get the Master of Public Health (MPH) degrees. In KIIs, PMOs said they want health worker trainings to be decentralized so they can do them on their own and with less cost.

[9] ZISSP Quarterly Report January – March 2013.

[10] Data included in ZISSP's routine PMEP reporting as of March 2013 are in Annex VII.

[11] See analysis of Zambia Management Leadership Academy (ZMLA).

ZISSP should review its training targets and follow-up with trainees to make sure they have the materials and supervision to implement what they have learned. ZISSP should also continue, and possibly increase, technical training at pre-service institutions. The issues of decentralized and cascade training approaches are for discussion at a level higher than the project.

In what ways has community participation in health planning, implementation, monitoring and improving health practices in ZISSP's target districts been strengthened?

Community health capacity building was added to HSS activities implemented by USAID's previous Health Services and Systems Program (HSSP). The purpose was to train NHCs to be engaged in community health planning as part of district annual plans, as well as to mobilize resources to support community health activities. Behavioral Change Communication (BCC) Committees and radio distance-learning groups have been formed and trained but their implementation has been relatively recent; therefore, it is too early to determine their effect. Many community volunteers, including infant and young child feeding (IYCF) volunteers, CHWs, and Community Based Distributors (CBDs) have also been trained. The most impressive groups supported by ZISSP, however, have been the SMAGs, who were trained through ZISSP's partner, ACNM, using a community-based curricula modeled on home-based living skills (HBLSS). Administrative data, KIIs and FGDs confirmed the perception that more women are going to antenatal care (ANC), post-natal care, and family planning clinics, and communities perceive the groups as effective in involving men in safe motherhood and improving women's health. SMAGs collected data is generally good quality. However, review of SMAGs' records indicates that more monitoring needs to be done to ensure that all pregnant women are registered and their information is accurate. Experienced SMAGs appear to be ready to expand their repertoire, including adolescent health, and possibly becoming CBDs for family planning.

ZISSP's role in the CHA program was limited to paying tutor salaries until early 2013, and training CHA supervisors. The Evaluation Team identified supervision problems in a survey of 81 CHAs who had been at their sites for approximately 8 months before the survey. According to the survey, one-third of CHAs had never been supervised. Of the 60% who had received supervision, most were supervised an average of three times (policy is monthly) and most of those visits took place 6 months or more before the evaluation.

The community grant program started in late 2012 so the majority of the activities were not yet fully implemented. Flow of funds and reporting requirements seem to be slowing down implementation, and the majority of funds in the project for grants have not yet been awarded. Community development planners from MCDMCH, who accompanied the team to communities, said that there are opportunities to link NHCs, SMAGs, BCC groups and grantees with some of their development programs that could provide continued support and sustain these valuable activities after the project is over.

Support for community activities should be continued and included in sustainability planning by ZISSP. Awards for the remaining community grant funds should be expedited and ZISSP should identify where implementation of existing grants can be streamlined. Results of the CHA supervision study should be shared with partners that support the program. Community development is not an area of ZISSP's expertise nor is it within its mandate and the evaluators do not recommend that ZISSP expand into those areas. However, ZISSP can provide information to communities on how to find MCDMCH offices in the districts in order to link with community development programs.

In what ways has the MOH's capacity to attract and retain health workers in rural positions improved? What are the perceptions of health workers who are currently on the Zambia Health Worker Retention Scheme (ZHWRS) about how effectively it is managed?

ZISSP's role in ZHWRS was limited to reimbursing incentives for less than 15% of workers in the program and providing a seconded staff member to help MOH implement the program (which has since been moved to MCDMCH). Likert Survey respondents and KIIs indicate that the program is helping to attract and retain health workers in rural areas. However, the program has significant management problems that have worsened since the seconded staff person left.

The ZHWRS is a valuable tool to address health worker shortages in challenging areas but the program needs considerable management strengthening to address HRH personnel problems.

ZISSP should offer to provide another seconded staff to MCDMCH to assist them with the ZHWRS and build better management capacity in that program. Other issues need to be addressed at a level higher than the project.

In what ways has coordination and synergy of HIV/AIDS, MNCH, Nutrition, Family Planning, and Malaria services provided by stakeholders (MOH, USG, other donors, private sector health facilities, etc.) in ZISSP target districts been strengthened?

Similar to other evaluation questions, there are no PMEP indicators that measure activities under Task 4. ZISSP's approach is based on partnerships, and they collaborate with several stakeholders through TWG and

stakeholders' meetings that they support at the national, provincial and district level. ZISSP also coordinates with other stakeholders at USAID partner meetings and interagency coordinating meetings, supports activities of provincial HIV/AIDS coordinating committees, participates in annual health planning and review processes, and jointly implements activities at all levels. Programs specifically identified by the Evaluation Team include Zambia Prevention Care and Treatment (ZPCT) II, CIDRZ, CARE International, CHAZ, UNICEF, MACEPA, SIDA, and all USG partners working in the Saving Mothers Giving Life (SMGL) districts[12]. Although ZISSP says it belongs to the PMTCT TWG, it could be more active in order to integrate several project interventions related to maternal and child HIV. The Likert Survey responses from both GRZ health officials and ZISSP's seconded staff gave high scores in all areas related to this question, indicating a perception that ZISSP's efforts in this area are being effective (See Annex VI, Table 5).

ZISSP has implemented activities as designated in Task 4 that address this question. Some of the challenges hindering ultimate impact of activities within ZISSP's mandate require high level collaboration and negotiation to solve, including through the Interagency Coordinating Committee (ICC) and Annual Reviews, as well as TWG, where partners working in other HSS sectors are members.

ZISSP should continue to participate within national collaborating venues related to its mandate and increase activity in the PMTCT TWG.

What is the perception of MOH, MCDMCH and NMCC regarding ZISSP's seconded staff's role in building capacity of GRZ counterparts to plan, design, implement, manage, monitor and evaluate health programs at the national, provincial and district levels?

As with other capacity elements other than training, there are no indicators in the PMEP to address this question. ZISSP placed seconded staff in MOH offices, including NMCC, and also at provincial levels, where they provide technical support to provinces and districts in planning, management, mentorship, and building capacity of community groups. Likert Survey responses rated this contribution as high and this was supported by KIIs with GRZ officials. NMCC told stakeholders that they will absorb the functions of the M&E staff person after the project ends.

Seconded staff's contributions to NMCC are considerable and ZISSP assisted the team to obtain an interview with the Acting NMCC Director, who was the only GRZ official at their headquarters at the time. Data to measure IRS activities is reported routinely and is included in ZISSP's reports. Case management and malaria and pregnancy responsibilities had recently been transferred to MCDMCH, who were not available for interviews in spite of multiple requests. GRZ officials responsible for IRS, resistance studies and surveillance were out of town or engaged with the PMI team (see limitations) during the evaluation field work. The team agrees with ZISSP that these are reasons for a further, more detailed, analysis of ZISSP's contribution to NMCC and national malaria efforts that includes more feedback from the GRZ perspective.

MCDMCH, MOH, as well as Provincial Health Office (PHO) and District Health Office (DHO) managers encouraged ZISSP to focus its efforts for the remaining time of the project on continued support to the districts and NMCC. ZISSP should also document lessons learned from the experiences of seconded staff at each GRZ level before the project ends, and include planning for turnover and/or completion of its activities as part of the exit strategy and sustainability planning. This process should start shortly after the evaluation. The NMCC has indicated they will retain the M&E position within the NMCC after the project is over and ZISSP should assist them to institutionalize this position's responsibilities[13].

To what extent have women been empowered to take action in support of health behaviors and interventions in ZISSP's target districts?

ZISSP's results framework includes a gender focus but not specifically "women's empowerment to take actions in health." Women's empowerment in health was not specifically included in the original award documents or project reports. Training indicators are broken down by sex but an indicator to measure "women's empowerment in health" is not included in their approved PMEP. ZISSP's recent internal gender strategy includes women's empowerment but is not specific and does not include indicators. ZISSP assisted the MOH to conduct a gender assessment and the MOH Gender Strategy was just completed (2013) but both sexes were included.

It is not clear if the women's empowerment focus from USAID has been clearly communicated to ZISSP. When evaluators asked ZISSP's staff questions about women's empowerment, the responses primarily related

[12] Zambia Behavior and Social Change Communications Program, Zambia HIV/AIDS Prevention Care and Treatment Partnership, Center for Infectious Disease Research in Zambia, Churches Health Association of Zambia, United National Children's Fund, Malaria Control and Evaluation Partnership, Swedish International Development Agency, Global Fund for AIDS, TB and Malaria.

[13] Drawing from lessons learned when GRZ adopted Provincial Clinical Specialists after HSSP.

to gender overall, especially increasing male involvement to support women's health. Likert Survey responses indicated a perception that there has been a slight improvement in acceptance of women in leadership positions at the community level.

If USAID intends for ZISSP to include women's empowerment to take action for health as a specific ZISSP focus, it should clearly instruct ZISSP to implement strategies targeting those outcomes and include ways to measure and report on them. This may require a change in the project description. ZISSP should, however, review its existing programs and seek opportunities, including in ZMLA training, where women's empowerment in health can be strengthened.

Issues for Discussion at a Level Higher than the Project

Effectiveness of capacity building and training in almost all of the technical interventions targeted by the project has been hindered to one extent or another in recent months by periodic stockouts of certain drugs and supplies, lack of essential equipment, inadequate district budgets, or weak supervision systems. Trained health workers are still waiting in some areas for the drugs and equipment they need to implement what they have learned. Drug supplies and logistics are not in ZISSP's mandate and, as of May 2013, only 38% of essential drug stocks were reported to be available at the national Medical Stores Limited (MSL)[14]. Some child health drugs, such as zinc for child diarrhea, were reported to district pharmacists[15] as not available. At the time of the evaluation, stockouts of Nevirapine for PMTCT were also reported in several locations[16].

Most districts visited by the Evaluation Team had received, by half way through 2013, less than 30% of the funds required to implement their annual plans. District budget shortfalls, procurement and supply challenges in the districts, and HMIS weaknesses are long standing, national in scope, and beyond ZISSP's mandate. Challenges in data quality and differences of opinion about estimating catchment populations are also long standing system problems that cannot be improved with short-term assistance or by one partner.

Lack of capacity building and sustainability indicators at the beginning of programs, along with no baseline assessments, make giving full credit of the contributions of an HSS program very difficult. The ZISSP COP said that the type of indicators they put into their PMEP were recommended by USAID when the project began. Overall failure to include coverage targets in the entire package of donor-supported public health programs in Zambia also will make impact assessments at the end of programs very problematic. However, there are capacity measurements available that could be used by many donor-supported programs to capture contributions even if they were not included in the PMEP from the beginning.

[14] JSI Deliver, May 2013.

[15] Interviews with District Pharmacists, Serenje and Mkushi Districts.

[16] Interview with ZISSP Southern Province Clinical Care Specialist and JSI Deliver, May 2013; interview with ZPCT2 provincial coordinator, Central Province.

1.0 EVALUATION PURPOSES AND PRIORITY QUESTIONS

1.1 EVALUATION PURPOSE

This is a report on the mid-term performance evaluation of the Zambia Integrated System Strengthening Program (ZISSP) funded by the United States Agency for International Development (USAID) Mission in Zambia. The project is implemented by Abt Associates.

The evaluation was conducted from March – July, 2013, by a team assembled by Mendez, England & Associates (ME&A) with headquarters in Bethesda, Maryland. The team consisted of two international and three local experts – all with experience working on and evaluating health projects in developing countries, especially in Africa.

The purpose of the mid-term evaluation was to assess ZISSP's progress towards meeting its goals and objectives from three perspectives and to make recommendations related to three evaluation objectives:

- **Objective A - (Retrospective):** Progress made toward achieving project objectives - from ZISSP's Scope of Work (SOW) - including Project Design (Conceptual Framework) in light of implementation experience and lessons learned to date.
- **Objectives Part B - (Prospective):** Based on the findings from Objective A, recommendations for ZISSP's project implementation through 2014, including optimal mix of activities and funding for achieving project objectives; sustainability taking into account the current Zambian Government structure that involves two ministries dealing with health; current Zambian health policies and; current U.S. Government (USG) policies.
- **Objectives Part C:** Using above findings (Objective A and B) frame issues to debate/discuss/resolve at a level higher than the project, e.g. at the level of the Government of the Republic of Zambia (GRZ) and/or other donor organizations.

1.2 EVALUATION QUESTIONS

The evaluation questions were:

1. What progress has been made in ZISSP's target districts towards improving access to and utilization of Family Planning; HIV/AIDS; Malaria; Maternal, Newborn and Child Health (MNCH); and Nutrition Information and Services?
2. What progress has been made to strengthen the capacity of the Ministry of Health (MOH)[17] and National Malaria Control Center (NMCC) staff at each level (national, provincial, and district) to plan, design, implement, manage, monitor and evaluate health programs within each of the five program areas: 1) HIV/AIDS; 2) Malaria; 3) Family Planning; 4) MNCH; and 5) Nutrition?
3. In what ways has community participation in health planning, implementation, monitoring and improving health practices in ZISSP target districts been strengthened?
4. In what ways has the MOH's capacity to attract and retain health workers in rural positions improved? What are the perceptions of health workers who are currently on the Zambia Health Worker Retention Scheme (ZHWRS) about how effectively it is managed?
5. In what ways has coordination and synergy of HIV/AIDS, MNCH, Nutrition, Family Planning, and Malaria services provided by stakeholders (MOH, USG, other donors, private sector health facilities, etc.) in ZISSP target districts been strengthened?
6. What is the perception of MOH, Ministry of Community Development and Maternal Child Health (MCDMCH), and NMCC regarding ZISSP seconded staff's role in building capacity of GRZ

[17] The split of health system functions between the MOH and MCDMCH took place in the middle of the ZISSP project period. The MCDMCH is included in the evaluation assessment.

counterparts to plan, design, implement, manage, monitor and evaluate health programs at the national, provincial and district levels?

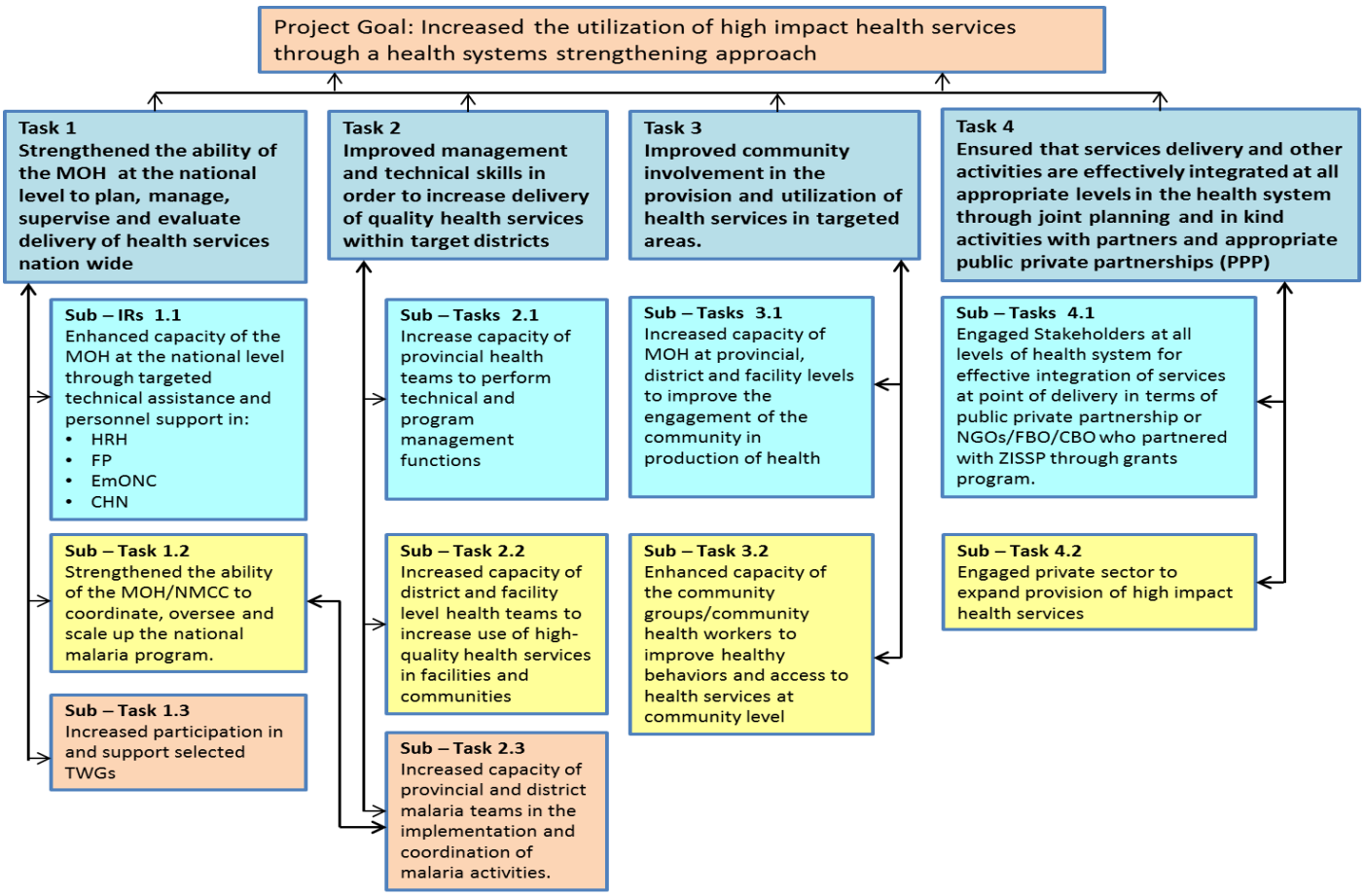
7. To what extent have women been empowered to take action in support of health behaviors and interventions in ZISSP target districts?

2.0 PROJECT BACKGROUND

ZISSP is a 4.5 year project that began in June 2010 and will end on December 14, 2014. The project's objective is to increase the utilization of high-impact health services through a health systems strengthening (HSS) approach using the World Health Organization (WHO) HSS "building blocks" definition. ZISSP's results framework is provided in the diagram below. The rationale for the project was based on the MOH's assessment that effective delivery of key health interventions to meet the Millennium Development Goals (MDGs) was hindered by multiple health system weaknesses impacting delivery at the health facility, community and household level.

The project was designed to address multiple health challenges exacerbated by those weaknesses in the health system. These included a highly-centralized human resource (HR) information system; insufficient production and uneven distribution of human resources; and difficulties retaining trained staff, especially in rural areas.

ZISSP's Result Framework



Other problems that ZISSP was designed to address included: 1) challenges in allocation and management of financial, human and technical resources in the health sector; 2) need for more effective engagement of and support for formal and community-based structures and their linkage to the planning process in a meaningful way; 3) gaps in achieving coverage of high impact services in districts of highest need that are accessible, affordable and of acceptable quality, with strategies that would address gender and age-related

barriers; and 4) a need to promote full participation of all sectors of the population in health behaviors and utilization of health services.
Task 4 originally included a provision for a public-private partnership (PPP) but this was dropped from the project as instructed by USAID at the beginning of the award because another USAID-supported PPP was already working in HIV/AID. There was also an optional Task 5 involving food security but that option was not exercised.

Under each of the four main tasks, increasing utilization of health services in all program technical areas is intended to come from improvements in management using the following strategies: 1) employing a whole-system approach to unblock obstacles and strengthen the delivery and utilization of essential services; 2) building Zambian capacity as the foundation for sustainability; 3) increasing impact through partner engagement and integration; 4) planning from the "bottom-up" to ensure relevance and participation; and 5) ensuring gender integration.

The ZISSP program specifically targeted the identified weaknesses in Human Resources for Health (HRH) and ineffective planning and management systems with approaches that were intended for: "1) improving allocation and management of health, financial, human, and technical resources; 2) supporting formal and informal community-based health structures; 3) meaningfully linking community representation to the health planning process; 4) targeting districts with the highest need for high-impact services; and 5) addressing gender and age-related barriers to access and full participation[18] in health services and information." Target provinces and districts[19] were selected with guidance from MOH and based on health indicators.

Abt Associates is the Prime Contractor and implementer of ZISSP. Subcontractors include the American College of Nurse Midwives (ACNM), AKROS, Johns Hopkins University Center for Communication Programs (JHUCCP), The Liverpool School of Hygiene and Tropical Medicine, Planned Parenthood Association of Zambia (PPAZ), and BRITE. A subcontract with Banyan Global to support PPPs was not implemented and Banyan Global has not been active in the project.

Challenges
The realignment of offices in GRZ between two ministries (MOH and MCDMCH), which occurred in the middle of the implementation of the ZISSP project, has injected uncertainty into planning activities at the national level and slowed down progress in some of them. However, district level day-to-day activities have remained largely unchanged. A 2009 financial scandal related to donor funds has also decreased some donor support for GRZ's health programs. On the other hand, GRZ has taken some positive measures towards sustainable change in the health sector by: 1) including WHO's Integrated Management of Childhood Illness (IMCI) in nursing pre-service curricula; 2) requiring District Medical Officers (DMOs) to have Master of Public Health (MPH) degrees; 3) upgrading job descriptions for District MNCH coordinators and making midwifery training a prerequisite; and 4) allowing MOH to take ownership of procuring the bulk of malaria drugs including Artemisinin-based Combination Therapy (ACT) and Sulfadoxine-pyrimethamine (SP). MOH has an approved budget from Parliament for the procurement of malaria drugs, and some supplies have already been purchased. MCDMCH officials found several potential linkages to their community development programs that could contribute to offset volunteer's lost income and contribute to sustaining community based program components in the project.

3.0 EVALUATION METHODS & LIMITATIONS

3.1 EVALUATION METHODOLOGY

The evaluation of ZISSP was not intended to be an impact evaluation. The Evaluation Team followed guidance in WHO's 2010 Operational Framework for Monitoring and Evaluating HSS programs and used a

[18] ZISSP, Statement of Work.
[19] See Annex XII.

non-experimental design that included a mixture of quantitative and qualitative methods. However, secondary data such as the Health Management Information System (HMIS) facility-based data, the Project Monitoring and Evaluation Plan (PMEP), and the Monitoring & Evaluation (M&E) system were not designed to answer several of the specific evaluation questions. In addition to available sources of data and two quantitative surveys, the team also used qualitative methods to collect data. These methods included extensive briefings from the project, 110 key informant interviews (KIIs) with GRZ and stakeholder national offices, as well as field visits to 5 provincial and 12 district health offices, health facilities, pre-service institutions and communities. The Evaluation Team also conducted 25 focus group discussions (FGDs) in rural communities in ZISSP-supported health facility catchment areas. A detailed description of evaluation methods for each question can be found in the Evaluation Matrix in Annex II.

Site Visits

Site visits included field visits to: 1) national GRZ and stakeholder offices; 2) five out of the nine original provincial health offices (PHOs); 3) 12 district health offices (DHOs) and health facilities; and 4) pre-service training institutions and communities in 12 of 27 ZISSP's focus districts[20], including two that are part of the Safe Mothers Giving Life (SMGL) initiative and one district where ZISSP directly conducts IRS. Two MCDMCH representatives, one from the national level and one from the provincial level, accompanied the team and provided input on the findings. Provinces and districts were selected by the team based on geographic location and criteria set in ZISSP's Scope of Work (SOW). In addition, ZISSP provided a list of districts where specific project interventions are implemented (see Annex XII: ZISSP's Program Intervention Areas), as well as a list of facilities within districts where the program is working. The final selection of KIIs, health facilities and the communities associated with them was made by the Evaluation Team in collaboration with the DHOs.

Document Review

Review of key documents related to project activities included: GRZ documents; USAID documents; the USAID Task Order; project documents including Annual Reports, Work Plans, PMEP reports; project study; guideline and training materials; health, population and nutrition policy and strategy documents; peer-reviewed technical literature; research reports; and project documents and reports from other USAID and development partner projects. A list of documents reviewed for the evaluation is included in Annex IX. ZISSP senior managers also briefed the Evaluation Team with overviews on most of their activities.

Quantitative Methods

Best available existing quantitative information included GRZ's HMIS reports and HMIS databases, health facility registers, SMGL registers, as well as infant and young child feeding (IYCF), Community Based Distributor (CBD) and Community Health Worker (CHW) registers and reporting forms. The 2012 MIS data were also reviewed and trends were compared with MIS and other malaria surveys conducted in Zambia since 2006. Health facility checklists were used to assess availability of health workers, the array of available health services provided, availability of drugs, equipment and supplies, as well as job standard operating procedures and updated guidelines. District level drug and supply request orders were compared with delivery documents in selected districts.

Quantitative methods used by the Evaluation Team included a Likert-scale Survey of opinions related to evaluation questions. The survey was administered to DMOs, PMOs, health workers on the Zambia Health Worker Retention Scheme (ZHWRS), and ZISSP staff seconded to the PHOs. The survey also included GRZ national headquarters and the NMCC. A second survey assessed Community Health Assistants (CHAs) experiences with supervision since assuming their duties after completing their initial training in 2012. Total sample size was 81 out of 270 CHA graduates attending in-service refresher training at Ndola Community School in April 2013. Survey participants were randomly selected from students in dormitories on the evening when the questionnaire was distributed. Data collected from the

[20] The Provinces were Central, Copperbelt, Eastern, Lusaka and Southern. Districts were Chongwe, Gwembe, Kapiri Mposhi, Luangwa, Luanshya, Lufwanyama, Masaiti, Mkushi, Serenje, Kaloma, Nyimba, Serenje, Sinazongwe

survey was entered into and analyzed using SPSS software. Survey data and a summary of results can be found in Annex V.

Qualitative Methods
ZISSP senior managers briefed the Evaluation Team at the beginning of the project; several follow-up KIIs were conducted afterwards. The team also met with the USAID Health Team members recommended by the Contracting Officer Representative (COR). 110 respondents were selected from the lists provided by USAID, ZISSP and GRZ managers. The team was able to meet with either the PMO or the acting PMO in four out of the five provinces, and the DMO or acting DMO in all 12 districts. At the PHOs and DHOs, the team met with any GRZ staff available and knowledgeable about project interventions. ZISSP's seconded staff was also interviewed whenever available. The Evaluation Team also conducted 25 FGDs with community health, family planning, nutrition volunteers, NHCs, SMAGs, CHWs and CHAs. In addition, eight rural health facility assessments were also completed. Consent forms were translated and signed before clients were interviewed. No personally-identifiable client data was collected.

A detailed description of the evaluation methods used to address each evaluation question can be found in Annex II.

3.2 EVALUATION LIMITATIONS

The WHO's Operational Framework for Monitoring and Evaluating HSS recommends using administrative data and project output measures to evaluate HSS programs[21]. Evaluators were able to get output data, primarily related to training from the project PMEP. This is not an evaluation, per se, but impacts on the extent to which some evaluation questions could be answered. Responsibility for some important GRZ health system functions was in the process of shifting from the MOH to MCDMCH, and the current location of some offices and personnel was not known. Some MCDMCH managers were also not available for interviews due to schedule and travel conflicts or illness. The same was true for some development partners.

The most recent aggregated administrative HMIS data at the provincial level is from 2011 and, aside from the Malaria Indicator Survey (MIS), no population-based surveys have been conducted during the project time period. There are differences in catchment population estimates between the Central Statistics Office and district planners who are using "head counts" from NHCs or IRS programs. These differences, real or imagined, could impact the value of coverage estimates related to high-impact health interventions[22].

4.0 FINDINGS, CONCLUSIONS & RECOMMENDATIONS

4.1 PROGRESS TOWARDS RESULTS

4.1.1 What progress has been made towards improving access to and utilization of Family Planning, HIV/AIDS, Malaria, MNCH and Nutrition Information and services in ZISSP's target districts?

According to ZISSP, its results framework is the basis for measuring results toward the overall goal of contributing to the utilization of high-impact health services[23].

ZISSP's interventions and results framework were not focused on technical interventions; instead, they were designed to address several (but not all) aspects of HSS as described in the WHO's six "building blocks" of HSS[24] that would lead to the overall results framework project goal. USAID confirmed that this was the original intention of the HIV/AIDS funding that ZISSP received. The evaluators attempted to

[21] World Health Organization, Monitoring and Evaluation of Health Systems Strengthening: An Operational Framework, 2010, Geneva.
[22] DHO, Kapiri District, May 2013.
[23] ZISSP Chief of Party, June 2013.
[24] WHO, Health Systems Strengthening, 2010.

assess elements of technical performance, access to services, effectiveness of care and efficiency of services[25] where they could.

ZISSP's most recent reporting[26] on its PMEP against project targets has indicators that measure training outputs and are, therefore, more relevant to the second evaluation question on capacity building. Those indicators measure neither access nor utilization of services or information and are not intended to determine impact-level results. Objectively verifiable data available is not sufficient to completely answer the question. Therefore, secondary sources of information, primarily the HMIS, were consulted in an attempt to answer the question and were triangulated with responses to the Likert Survey and with KIIs and FGDs.

Responses to the Likert Survey related to this question indicated that while progress has been made, there is still more that needs to be done. Results of the survey show that ZISSP's seconded employees gave higher scores than GRZ health officials[27] (see Annex VI, Table 1 for samples sizes and scores).

ZISSP's program approach and results framework includes HSS approaches that if successfully implemented are known to lead to increased access and utilization in all technical areas included in the system. These approaches include improving quality of services; accessibility; workforce planning and leadership; education and training programs; and support services such as supplies, medications, equipment and use of data. According to USAID, overall health systems strengthening was this was the original purpose of ZISSP's project interventions, especially in HIV/AIDS, but was applied to the other interventions. The Evaluation Team found evidence that ZISSP is effectively working in all of those focus areas. Feedback from DHO managers in the KIIs indicated that ZISSP's support in these areas has been extremely important, highly-acceptable, and perceived to be improving the quality of work done by managers. The project's PMEP, however, does not include indicators that measure these improvements in management capacity.

Malaria

Malaria is a major area of focus and ZISSP funds six staff positions that are seconded to the NMCC, where they are involved in M&E, insecticide resistance studies, developing IRS and long-lasting insecticidal nets (LLIN) databases, conducting epidemiologic surveillance, and organizing sentinel sites. Additional information on malaria activities is included in the capacity building section of the report. The IRS objectives are aligned with the NMCC and the President's Malaria Initiative (PMI), and the M&E includes a coverage indicator of spraying at least 85% of the housing units. Coverage last year was 86%, exceeding targets. Some districts reported coverage of over 90%[28].

NMCC has a target that at least 90% of malaria patients in all districts should receive prompt and effective diagnosis and treatment by 2014. ZISSP supports intermittent presumptive treatment (IPT) training through Focused Antenatal Care (FANC) in 4 of the 12 districts visited by the Evaluation Team[29]. Another strategy of the ZISSP program to increase access to utilization of malaria services has been through strengthening BCC services and community committees to plan, manage and monitor interventions in health services. SMAGs also promote FANC that includes malaria in pregnancy, LLINs, and three doses of IPT. Annex IX presents graphs depicting IPT utilization in the four ZISSP districts visited by the Evaluation Team where health facilities implement FANC. An increase in the number of pregnant women accessing IPT was recorded, although increases in IPT_3 have remained lower than IPT_2, and increases in IPT_2 have remained lower than IPT_1 (see Annex IX). This is consistent with national trends as measured in periodical national surveys.

HIV/AIDS

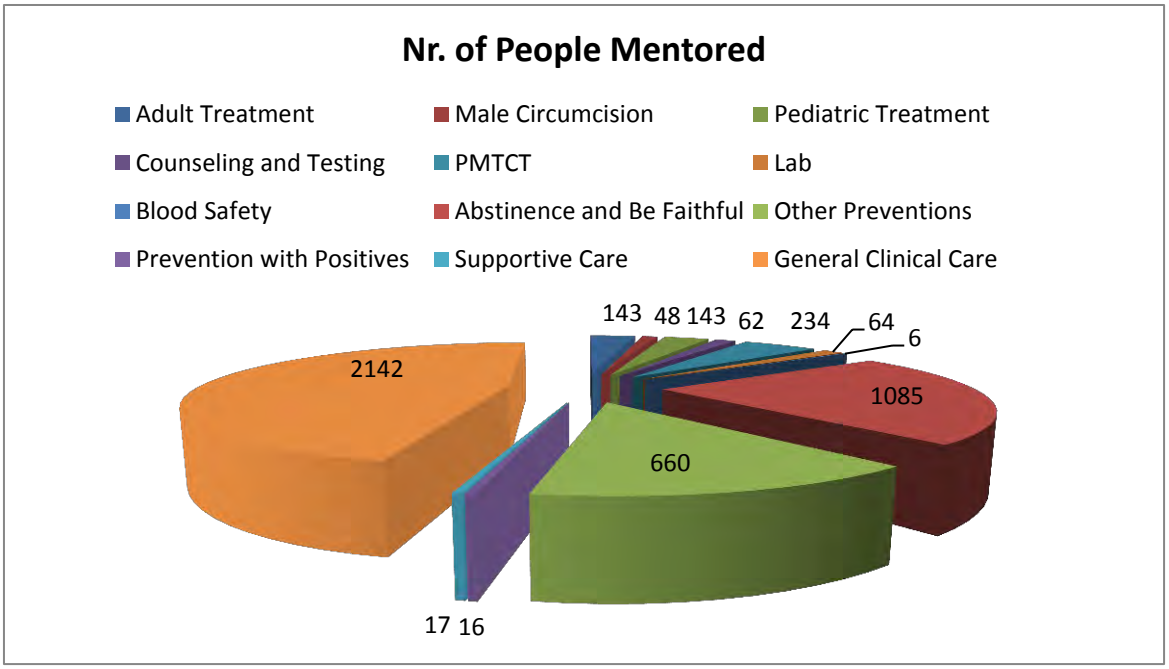
According to USAID, it was always the intention that ZISSP HIV/AIDS funds would be used for Human Resources for Health (HRH) activities, including the ZHWRS, Human Resource Information System (HRIS)

[25] USAID GH/HIDN Child Survival and Health Grants Program, Technical Reference Materials for Quality Improvement and Health Systems Strengthening, 2007 and 2010 , respectively.
[26] ZISSP Quarterly Report January – March 2013.
[27] See a detailed description of the Likert Survey in Annex XX and the survey results in Annex XX
[28] ZISSP Quarterly Report Jan – March 2013.
[29] See Annex XII for more information about districts where specific ZISSP activities are implemented

and in-service training (including clinical mentorship)[30]. These activities and ways of assessing them are specifically addressed in other sections of this report.

KIIs with ZISSP Clinical Care Specialists, and reviews of performance assessments and mentoring checklists confirmed that HIV/AIDS, family planning, malaria, and MNCH were all included and supported but specific IYCF assessments were not. Evaluators also found that performance assessment checklists contain several HIV/AIDS components. SMAGs and community grant programs specifically address most program interventions and are documented. UNICEF, however, reports that PMTCT is faltering nationally. Although 98% of pregnant women are tested for HIV/AIDS, only 28% of HIV-exposed infants are followed up with after birth. It is unclear why ZISSP is not more involved in strengthening PMTCT- specific activities given their involvement in several areas that are important for quality PMTCT.

As of December 2012, ZISSP also reported that it had provided mentorship to health workers in HIV/AIDS covering the following areas:



This is likely to increase as mentorship is demand-driven and does not have specific targets[31]. Two of the five MOH quality improvement (QI) indicators that ZISSP uses are specifically related to HIV/AIDS, but QI had only started shortly before the evaluation took place and no data were yet available.

Maternal Newborn and Child Health

Safe Motherhood

The HMIS documents and SMAG registers record skilled delivery, ANC, post-natal care and referrals for complications. Administrative data indicate increases in all of these areas but because of the large numbers of partners involved, they cannot be attributed solely to interventions implemented by ZISSP. KIIs and FGDs conducted during field visits confirmed impressions that there have been increases in key safe motherhood behaviors.

ZISSP's efforts to strengthen access to newborn care are included as part of Safe Motherhood within MNCH, and data might be co-mingled with Safe Motherhood data. The National IMCI protocols also include a specific algorithm and job aid for the IMCI for babies from birth to two months of age, which ZISSP uses in mentorship training. ZISSP conducted a study of health facilities for conditions that would qualify for "Baby Friendly" status early in the project[32], but as of mid-2013, the planning for Baby Friendly

[30] Comments provided by USAID on draft MTE report, June 14, 2013
[31] Provided by ZISSP to MTE team June 15, 2013.
[32] ZISSP BFHI Study, December 2011

Hospital Initiative (BFHI) activities was just starting. At the time of the evaluation, ZISSP was also involved with the MOH in developing national guidelines for newborn care.

Child Health

ZISSP reports that it supported improving the Reach Every District (RED) strategy in selected districts, and that clinical mentorship is supposed to include child health. Health workers told the Evaluation Team when it visited health facilities that they often could not provide routine vitamin A supplementation or deworming due to stockouts but these were given during Child Health Days[33]. The number of children that received DPT–Hib+Hep third dose was largely on the decline in most districts and health facilities visited by the Evaluation Team. This is a quality of care issue and it should be of major concern (see Annex XI). DHOs interviewed about challenges in child preventive health services said they had found immunization coverage problems were related to cold chain problems and poor capacity of community committees, as well as inadequate outreach services by the health workers. The Evaluation Team collected data from the HMIS on DPT-Hib +Hep third dose in Sinazongwe district and analyzed HMIS immunization data from other districts that documented decreased coverage in 2012 from previous years. The DMO in Sinazongwe district and the ZISSP seconded staff in Southern Province have targeted that district for additional technical support because of identified weaknesses. Data from Sinazongwe and the other districts can be found in Annex XI.

Family Planning

ZISSP is the technical lead for the family planning technical working group (TWG) at the national level and also provides support to the GRZ through a seconded family planning Focal Person now housed in the ZISSP office and also at the MCDMCH. At the time of the evaluation, she was the only family planning personnel in the MCDMCH office as the counterpart position was vacant. Other partners on the family planning TWG say that the group is working hard to put family planning higher on the national agenda (see Integration and Coordination related to Task 4).

Nutrition

Aside from breastfeeding promotion and collaborating with the National Food and Nutrition Program (NFNC), ZISSP technical managers say that their role is primarily to support implementation of the GRZ nutrition programs that focus on growth monitoring and identifying malnourished children in all children under five. At the time of the evaluation, the NFNC was in the process of rolling out the "1000 Days Strategy," and any other community-based nutrition activities may be impacted by that program. IYCF is an integrated approach to "high-impact" nutrition in the infant and child and is included in the national "1000 Days Strategy." Malnutrition (even mild and moderate), as measured by anthropometry, contributes up to 50%[34] of mortality and should receive significantly more attention in USAID-supported health programs in Zambia. Data is collected and reported to the HMIS from outreaches but DHO nutrition focal persons do not receive IYCF volunteer data.

CONCLUSIONS

Evaluators believed that this evaluation question was open for more than one interpretation and asked for more information about activities in specific technical areas in ZISSP's mandate and what they have been required to track. This type of question usually requires coverage data which is beyond ZISSP's mandate. While covered in ZISSP's overall HSS approach, several specific technical areas are addressed in broader program approaches such as strengthening routine performance assessments and providing mentorship to provide the supportive supervision that is necessary for all health programs to succeed.

The evaluators also believed that ZISSP's malaria activities are so extensive and varied that they could benefit from a more detailed review of their own. NMCC officials were not available to provide feedback on several aspects of the malaria program, and clinical services for case management and IPT have recently been transferred to MCDMCH. Also, the officials responsible for child health were not available for interviews.

[33] Health worker interviews in rural health centers in Masaiti, Luanshya, Lufwanyama Districts, and interviews with DHO pharmacists in Serenje and Mkushi districts.

[34] Bulletin of the World Health Organization, 2000, 78: 1207-1221.

The project's PMEP lacks capacity building indicators and is not designed to capture information that would allow ZISSP full credit for all of its contributions to access and utilization of health services. Similarly, project monitoring data is not designed to answer intervention-specific progress toward impacts. Most of the objectively verifiable project indicators are training outputs and are addressed in the Capacity Building section.

RECOMMENDATIONS

If USAID would like questions related to specific technical interventions to be answered, it should provide guidance to ZISSP about how they would like the data collected and for what they would hold ZISSP accountable, given the short time remaining and ZISSP's mandate. If the overarching activities such as mentorship, performance assessments, QI and HRH strengthening are what ZISSP was funded to do, then USAID and ZISSP should determine how success in these areas should be appropriately measured and allocated to the individual health interventions and how ZISSP can be credited with contributions it has made.

4.2 CAPACITY BUILDING

4.2.1 What progress has been made to strengthen the capacity of MOH[35] and NMCC staff at each level (national, provincial, and district) to plan, design, implement, manage, monitor and evaluate health programs within each of the five program areas (1) HIV/AIDS, (2) Malaria, (3) Family Planning, (4) MNCH and (5) Nutrition?

Scores in the Likert Survey relating to this question (Annex VI, Table 2) from both GRZ health officials and ZISSP seconded staff were higher than those responding to the first question (progress towards improving access and utilization). This might be because ZISSP is largely a capacity building project and HSS is the emphasis of the overall program. Both GRZ and ZISSP staff respondents felt good progress has been made in these areas, and KIIs with GRZ officials at all levels supported these findings.

Overall Health Systems Strengthening

Much of the early part of the project consisted of studies at the national level, planning activities with the MOH, and reviving dormant TWGs. Annex IX provides a list generated by ZISSP of over 40 formal reports, studies, strategic plans, guidelines and training tools[36]. Of these documents, only 16 (40%) focused on the 5 interventions: MNCH (10), Malaria (3), Family Planning (2), Nutrition (1), and one additional family planning study is currently underway. This is not surprising because ZISSP is an HSS project working across the WHO building blocks. Some of the GRZ national guidelines that ZISSP has contributed to, such as quality improvement, clinical mentorship and behavioral change communication (BCC) frameworks would be considered cross-cutting for all interventions. ZISSP is planning a study on the feasibility of ORT corners in health facilities for 2013 according to their workplan[37].

ZISSP worked with the MOH to build HRH capacity within the Directorate of Human Resource and Administration (DHRA). In January 2012, ZISSP conducted a capacity needs assessment for the Directorate, which identified poor records management as a major problem. Therefore, ZISSP trained 53 records management staff and registry clerks in HR planning and records management. Improvements in performance were reported from that office. Since then, the MOH has purchased computers for the Registry Department for an electronic file tracking system to be rolled out to provinces in 2013. ZISSP also provided support to update the MOH payroll system that was causing many health workers to be paid late. In addition, ZISSP produced a report that described the steps that the MOH would need to take to have direct access to a Human Resources Information System (HRIS). Although the system is not yet operational, the Cabinet Office has promised financial support to decentralize it.

[35] The split of health system functions between the MOH and MCDMCH took place in the middle of the ZISSP project period. The MCDMCH is included in the evaluation assessment.
[36] A list of documents produced by ZISSP and their status as of 2013 is provided in Annex IX.
[37] Comment from USAID June 2013 and evaluators agree.

ZISSP provided further support to develop a standardized HRIS system prototype to manage HR data, including staff hired, people due for retirement, and worker trainings. Once finalized, this system will be piloted in one province. MOH HRH officials credit DHRA quarterly performance review meetings, supported by the ZISSP seconded HRH Specialist, with leading to notable HR improvements. In June 2012, DHRA received a letter of commendation from the Commission Secretary, Public Service Commission at the Cabinet Office, for the notable, effective, and efficient processing of HR cases. According to USAID, more than 30,000 staff have been moved from MOH to MCDMCH, and the latter lacks the capacity to manage this extensive increase in the number of their staff[38].

Zambia Management and Leadership Academy (ZMLA)

The Likert Survey looked at both the perceptions of ZMLA training and the extent that it should be expanded to enable more health managers to improve their skills in management, planning and problem solving (see Annex VI, Tables 2 and 9). PMOs and DMOs provided evaluators with the same information in KIIs during field visits.

One of ZISSP's key strategies for building capacity at the provincial and district level is through the ZMLA training program. Through its partner (BRITE) and in collaboration with GRZ's National Institute for Public Administration (NIPA), ZISSP has supported the development and roll out of a management and leadership training program tailored to address weaknesses in district and provincial health management teams' capacity in planning and management, which were identified in a needs assessment completed at the beginning of the program. BRITE adapted a generic curriculum that it had implemented elsewhere in Southern Africa[39], which used an in-depth, consultative approach[40] with MOH stakeholders from the central, provincial and district level. The curriculum includes six core modules, delivered in quarterly workshops over a year, and addresses problem definitions, basic supply chain management, project/program management fundamentals, HR management, finance and budgeting, strategic information, and use of data for decision-making. The training uses case studies based on real problems and needs that are not included in pre-service medical training. ZMLA training is often the first opportunity for Medical Officers, Clinical Officers and other clinicians to learn the management skills they need to do their jobs.

The training also includes hands-on practice with HMIS and health facility data using data forms introduced at site visits. Participants learn about how data sources are generated, how data is meant to be used and about data audits. They also learn how qualitative data collected at the community level does not feed into HMIS (e.g. CHA monthly reports). Information Officers provide trainers with actual and current data challenges with which to work.

> "What has been most outstanding is the ZMLA training organized by ZISSP through BRITE. You can see the practical improvement. For example, management of meetings is much more effective. We also went through problem identification, and setting out priorities. As a district we have managed to set priorities right, for instance we have very little money in the grant, but were able to look at a lot of factors and which interventions bring you the most outcomes. Those things came out through training. Now we spend more time trying to analyze causes and set priorities (Nyimba DMO, District Health Office)."

The ZMLA approach is to train cross-sections of district or provincial teams to ensure that there is broad competence and shared understanding of the management concepts and tools. It has included a few partners, NGO staff and community leaders to extend these skills and tools to all levels.

NIPA trainers also have a role in follow-up group mentoring activities. ZISSP's Management Specialists seconded to PHOs also provide one-on-one follow-up coaching during

[38] Comments from USAID June 2013.

[39] Originally developed in Botswana in early 2000s to support massive scale up of PEPFAR programs.

[40] Content development process includes senior MOH officials from MOH; PMOs and DMOs are part of this process and also trained as mentors. For HR curriculum content, HR officials are consulted; similar expertise is included for all content, which has been vetted by many people. After initial trainings, additional revision was done based on participants feedback. The training is evaluated through pre and post self-assessment, knowledge pre and posttest for all modules, and feedback during follow up coaching and mentoring sessions.

technical support visits[41]. The Management Specialists based in the Southern and Eastern provinces described these coaching visits as an opportunity to train PHO colleagues on how to provide coaching support. BRITE is currently developing a website (to be activated soon) where all course participants will have access to online discussions moderated by mentors. Contacts are provided for both mentors and participants to allow for a "community of practice" and ongoing shared learning.

> "We have worked on monitoring and evaluation (M&E). For the case study, we set objectives and time frames for meeting them. We worked in 4 groups: one focused on ANC, one on post-natal care, one on EmONC and one on institutional deliveries. We identified these as problem areas and then set goals. One goal was to increase post-natal care from 45% to 80%. So we put many things in place, set up the HC as an EmONC site, and got a trained staff in EmONC. We (received) some supplies from the (government) (ZMLA Trainee, Copperbelt PHO)."

Participant selection was based on a ranking of the 27 ZISSP target districts in terms of performance and prioritization of districts that required more support. To date, the training has been rolled out to 9 ZISSP target provinces and 9 of 27 target districts. ZISSP reports that 1,409 students, out of an LOP target of 2,304, have completed ZMLA training[42]. The second cohort of students had just started at the time of the evaluation. ZISSP has also supported training of 68 MOH mentors (19 females and 49 males) using the same modules to prepare them to continue supporting the mentorship program.

KIIs with ZMLA trainees, representatives of the MOH, the Technical Support Services Directorate, PMOs, DMOs, and other PMO and DHO management team members revealed their perception that training was highly valuable and extremely effective in improving their management skills[43]. One trainee said "I never knew some of these responsibilities were part of my job[44]." NIPA trainers reported that they have been approached by other workers in the public sector who have heard positive feedback from MOH colleagues and would like to be trained. According to BRITE, the Chair of another government division requested a concept paper from them on how the modules could be adapted across other sectors.

> "With ZMLA, we've trained people in leadership and management; this was just scratching the surface, we haven't even trained a quarter of the people we want to train. What we have seen is that this training is worth going through, especially for people in hospitals, districts. Maybe we need to decentralize it to the provincial level in terms of management of training, this is part of governance, you target leadership. The benefits are huge (PMO, Eastern Province)."

While the training program has generated demand, given rises in training costs due to the daily subsistence allowance (DSA) and fuel cost increases, ZISSP has not increased the LOP target. According to ZISSP senior managers, they expect to fully meet the original target for individuals trained; however, not all target districts will have received training by the end of 2014.

Capacity Building to the Districts

The major program emphasis at the provincial and district levels has been improving the function and management of DHOs through improving planning and management skills, and increasing effective supportive supervision. ZISSP has provided substantial and "side-by-side" technical support to DHO teams for more effective annual planning. Planning starts with analyzing the PAs. Information gathered is discussed in technical management meetings, and is used to prioritize focus activities for the next year and identify key focus areas for mentoring. PHO and DHOs in KIIs praised the support for individual capacity strengthening and the Management Specialists who sit with them as they learn better management skills. The Deputy Director of the MOH Directorate of Technical Support Services also praised ZMLA and the Performance Assessment Tools supported through ZISSP as particularly helpful in building managers' skills in "problem identification" and "project management," which were weak in all districts. This assistance gave them a clear guide on how to make improvements. DHOs reported that they are much better able

[41] Per BRITE, 50% of the Management Specialists' time is supposed to be dedicated to ZMLA activities, including training and training follow up coaching and technical support activities. The training activities links directly with the planning and performance review processes supported by the Management Specialists.
[42] ZISSP Quarterly Report, January – March 2013.
[43] PMO Copperbelt, PMO Central Province, multiple DMOs interviewed by the MTE team, April –May 2013.
[44] ZMLA trainee, Copperbelt PHO.

to organize productive meetings, manage their time, and prioritize actions. Better planning skills help DHO managers assist health facilities contribute to District Annual Plans.

Multidisciplinary Clinical Care Teams have been formed and provide mentorship to improve individual health workers' skills based on the PAs' and mentorship targets' weak areas. Mentorship combines supportive supervision with one-on-one clinical observation and coaching. All DMO and Clinical Officers interviewed praised the mentoring approach and thought it was a real gift to helping them support improved health worker performance in challenging conditions. They said they would continue mentorship if sufficient resources were available.

QI is another area that ZISSP is emphasizing in the districts, including some "model sites" in facilities located in districts not targeted for other project activities. ZISSP has started by forming QI teams as part of the process. Health facility managers that attended a QI training praised it as helping them better understand QI issues when they examined another facility's records to see what was and was not done correctly. They brought those skills back to their own facilities. The overall step-by-step approach of implementing QI was less clear to the Evaluation Team in spite of multiple questions about it. USAID explained that QI was a government program that was relatively new and that ZISSP is organizing its QI activities to fit with the MOH plans. These include identifying a small number of "model facilities" where QI activities will be concentrated and show results. Some of these "model facilities" are not located in ZISSP's focus districts but are located in focus provinces. According to USAID, this model was agreed with GRZ after the launch of the national guidelines. ZISSP's Clinical Care Specialists explained that the QI indicators "came from the government" and include: confirmed malaria cases; maternal mortality; child mortality; pediatric HIV diagnosis; and antiretroviral (ARV) patients retained on medication. However, they do not include family planning or nutrition measurements. The evaluators believe that these are important omissions but assume that additional indicators would need to be negotiated with GRZ.

Health Worker Training in Technical Areas

Much of the technical area-specific activities in ZISSP are related to health worker training and, to a lesser extent, to health worker supervisor training. Most training employs a cascade method utilizing master trainers for training of trainers (TOT) who then train health workers. Follow-up visits to assess health workers' new skills with or without elements of supportive supervision only takes place for short periods of time after the trainings are part of the methodology. "Hands on" experiential training in some interventions often takes place in high-volume clinical care environments such as a provincial or referral hospital. Most health worker trainings did not start until 2011, with the majority of activities conducted in 2012. Cascade training is a time consuming process, especially if master trainers are selected from GRZ staff with other responsibilities.

ZISSP's approach to increasing access includes increasing the number of health workers trained in several technical interventions, some of which are already integrated. These include IMCI, FANC, and IYCF. ZISSP also contributes to increasing the numbers of health workers trained in emergency obstetric and newborn care (EmONC), which integrates maternal and newborn care. Training community volunteers in integrated community case management and IYCF, as well as SMAGs and CBDs for family planning, is designed to increase access by extending outreach from fixed health facilities. Health promotion and BCC strategies are supposed to decrease illness, promote care seeking, and mobilize communities for safe motherhood and newborn care. ZISSP has succeeded in training large numbers of health workers, community volunteers, and community members in all of the five health intervention areas (MNCH, HIV/AIDS, FP, malaria and nutrition) targeted by the project; however, it combines several training activities into one indicator. Examples include numbers of health workers or community volunteers trained in "reproductive health" or "child health and nutrition." This prevents measuring project outputs related to specific individual training activities such as family planning or IYCF practices. PMEP data of trainings against project targets is included in Annex VII.

HIV/AIDS

ZISSP's QI indicators for health facilities include two HIV/AIDS indicators, one for pediatric testing and the other for ARV retention[45]. SMAG training materials developed by ACNM for the ZISSP program are used to integrate strong emphasis on couples testing as part of ANC, and include content on following up with infants[46]. Couples' testing is also included in community BCC messages promoted through ZISSP's Provincial Community Health Coordinators[47]. At least one Community Grant was awarded to a faith-based NGO in Serenje, whose activities are specifically focused on HIV prevention, testing, and care seeking in ZISSP's health facility catchment areas[48]. FANC training for health workers also includes testing for HIV, placing HIV+ mothers on ARV drugs, and providing information about follow-up after the baby is born.

Malaria

ZISSP is involved in multiple areas of malaria capacity building (see Capacity Building Section); however, only a few areas have data related to malaria measured in the project's PMEP. For instance, the MOH QI indicator for confirmed malaria cases is not included. Likert Survey scores indicated perceived improvements from ZISSP's capacity building to develop databases (see Annex VI, Table 2).

According to ZISSP's senior managers, ZISSP collaborated with NMCC to train Indoor Residual Spraying (IRS) operators and ensure conformity with the national and WHO IRS guidelines in its districts. ZISSP also established a formal IRS TWG that is intended to engage partners and provide leadership in IRS. The project manages five sentinel sites for resistance monitoring. It paid the IRS spray operators and their immediate supervisors in the districts as part of its support to spray housing units and buildings twice a year[49]. USAID explained that this only happened in the past season because two districts utilized short-acting insecticides in two phases, meaning that structures in those areas needed to be sprayed twice during the last season[50].

Spraying in the PMI districts could not begin until the national launch took place and it was postponed several times[51], only to occur when it had already started raining. IRS managers attributed increased refusals to the late start when families would not remove their belongings and put them outside in the rain. ZISSP seconded personnel at NMCC trained GRZ personnel to use Geographic Information System (GIS) to identify eligible households in 2010 and additional training has taken place each season since[52]. GIS mapping is supposed to be repeated every three years[53] and not enough time had elapsed for it to be repeated, even though new structures may have been built. Responses to IRS questions in the Likert Survey rated performance relatively high but also indicated that more should be done, showing a felt need for further assistance in this area (see Annex VI, Table 8). Support for databases was one of the higher ratings. Case management for malaria is included as part of activities in Integrated Management of Child Illness, as well as Integrated Community Case Management (iCCM), and is not done separately. ZISSP has also trained health workers to be IMCI supervisors and trained CHWs in iCCM. Malaria case management is also included in performance assessment mentorship activities and QI activities supported by ZISSP.

ZISSP conducted behavior formative research into issues related to intermittent preventive therapy (IPTp) uptake. IPTp and use of LLINs are included in FANC training, and SMAGs and BCC activities promote LLIN usage. However, several health facility catchment areas have not had general LLIN distribution since 2008 and nets for pregnant women and children under five were stocked out in many health facilities. On the other hand, districts in the Central Province reported 98% coverage of LLIN and additional IRS coverage of about 20%; however, malaria incidence showed very little decline from 2009 through 2012[54].

[45] Indicator list provided by ZISSP Clinical Care Specialist, Copperbelt Province.
[46] KII with Mary Carpenter, ACNM SMAG focal person, May 2013 and relate to ZISSP's Task 4.
[47] KII with ZISSP CHCs, Copperbelt and Central Provinces, April-May 2013.
[48] Serenje Pastor's Assn Director and Senior Accountant Interview, May 2013.
[49] Some insecticides require twice yearly spraying.
[50] Comment from USAID, June 2013.
[51] Ibid.
[52] ZISSP Annual Reports and ZISSP.
[53] Follow up interview with ZISSP.
[54] Serenje and Mkushi District MIS.

ZISSP does not procure or distribute LLINs but is heavily involved in promoting malaria behavior change messages through many of its activities, including SMAGs, NHCs and BCC groups at the national level, and part of ZISSP's database support to NMCC includes collecting data on LLINs that are present in homes receiving IRS[55].

ZISSP has provided technical assistance in important research that is needed to guide national malaria policies and programs and build M&E capacity in partnership with the NMCC. These include the Lusaka prevalence study, insecticide resistance studies, establishing sentinel surveillance sites and developing databases with the NMCC. These activities, however, do not have indicators included in the PMEP (aside from the IRS and IPTp activities already mentioned) that can be measured. Multiple attempts to schedule interviews with some key malaria managers at NMCC were not successful due to travel and participation in the PMI team annual visit. The team was able to meet with the Clinical Care Manager, who was also acting as NMCC Director during the beginning part of the evaluation. She provided feedback on several areas where ZISSP is involved, but encouraged the team to meet with the NMCC Director and the IRS Manager when they were available.

Family Planning

Family planning[56] in Zambia has received support from multiple donors for many years and many partners including PPAZ, UNFPA, and Marie Stopes International. Family planning services are included in all health facility service packages and the Evaluation Team found several contraceptive methods available in all health facility visits. In most cases, Depo Provera, oral contraceptive pills and condoms were available. As of the end of March 2013, ZISSP had trained 195 health workers in family planning against an LOP target of 360[57], including tutors in pre-service institutions of nursing and midwifery. Aside from training tutors, many long term family planning trainees interviewed by the evaluators said that they could not yet implement their new skills in implants and intrauterine device (IUD) insertion due to lack of equipment and supplies, even though they had been ordered through MSL. USAID, PPAZ, JSI and other development partners interviewed for this evaluation expressed surprise when they heard of the lack of supplies as they thought that there were sufficient contraceptive supplies available at the national level[58]. Tutors at the DEM School in Luanshya said that demand is high for implants but low for IUDs. This was confirmed by the HMIS data in the districts and health facilities visited by the Evaluation Team as shown in Annex X. ZISSP is conducting a long-term family planning training impact study but results will not be available until later in 2013. ZISSP has also trained 189 community members against an LOP target of 540 as CBDs in selected districts, and there are plans to train many more in selected areas next year. Family planning promotion messages are also included in SMAG training, NHC and BCC group messages. The Evaluation Team saw family planning messages promoted by SMAGs in a community meeting[59].

ZISSP has trained CBDs in selected districts and plans a massive scale-up in one district next year. This is apparently at the request of MOH. It is unclear how the lessons learned related to CBD sustainability after external funding ends, have been applied to CBD training.

Overall, the Evaluation Team found that aside from SMAG training to promote family planning, there was very little direct evidence of integration of family planning with the other target interventions but many opportunities where this could be done. ZISSP responded, however, by pointing out where family planning is included in the PAs that are the basis for mentorship in all of their districts. One clear area would be to train experienced SMAGs as CBDs, so they could follow through on their promotion of family planning. Several partners, including ACNM, think this is a good idea. SMAGs are also a venue for engaging in the new Adolescent Reproductive Health Strategy[60].

[55] ZISSP NMCC seconded staff.

[56] At the time of the MTE, responsibility for family planning had been moved to MCDMCH and the GRZ family planning was vacant. The ZISSP seconded staff, a PPAZ employees was serving as both ZISSP technical support and essentially functioning as the GRZ family planning.

[57] ZISSP Quarterly Report Jan-March 2013.

[58] KII with USAID MNCH/FP focal person, JSI Senior Pharmacist, DFID Health Focal Person PPAZ Senior Managers and UNFPA representatives, May 2013.

[59] SMAG community meeting Luanshya District, April 2013.

[60] GRZ MOH Adolescent Reproductive Health Strategy, 2012.

ZISSP should review project activities with a "family planning lens" and provide appropriate technical inputs to strengthen family planning.

Maternal, Newborn, and Child Health (MNCH)
ZISSP trains health workers and community volunteers in several aspects in SM and is one of the partners in the four SMGL districts. ZISSP's partner, ACNM, adapted Home Based Life Saving Skills (HBLSS) for SMAG training.

ZISSP has trained 253 out of 340 targeted health workers in EmONC. The impact of the EmONC training, however, is limited in some health facilities where some trainees work and equipment, such as oxygen tanks and supplies, have been ordered but not yet arrived. According to district MNCH coordinators who were available for interviews, as well as some health workers who attended the trainings, they received some delivery beds and suction equipment after training (not supplied by ZISSP) but the remaining EmONC equipment must come from other sources.

Supplying equipment and drugs where they are not currently available is not part of ZISSP's mandate but those needs would have to be addressed by other partners for increased access and utilization to take place. According to USAID, there are other donors, such as World Bank and DFID, who have procured EmONC equipment but evaluators were not able to confirm that those donors were supplying equipment to all facilities where ZISSP trainees are working. According to USAID, the MOH and National EmONC TWG developed a schedule for distribution of equipment and identified some challenges to equipping them. For example, some facilities did not have adequate space, power or water supply[61]. Trainees who were interviewed by the Evaluation Team said they were very pleased with the high quality and "hands on" approach of the training and confirmed that it has helped them recognize danger signs requiring action, and increased their timely referrals to higher level facilities when needed.

Focused Antenatal Care (FANC)
FANC is an evidence-based, high impact integrated approach to ANC that integrates many of the ZISSP's focus technical areas where it can be implemented. ZISSP has supported many health workers to attend FANC trainings, and trainees find that the quality of these trainings is very good. FANC is meant to increase access and utilization of important MNCH health services, but it has suffered from many of the same barriers in health service delivery (supplies, drugs, supervision and use of data) that are impacting the other health technical interventions, especially those that require commodities. For example, in 2011, there were over 18,000 deliveries in Serenje district but less than 3,000 pregnant women were recorded as tested for syphilis[62]. Health facility records show regular stockouts of urine test kits, (some) HIV test kits, and broken Hemacues.™ This was confirmed by the national focal person for FANC in the MCDMCH.

Safe Motherhood Action Groups (SMAGs)
ZISSP has trained SMAG Master Trainers in provinces and districts, including two SMGL districts, and also trained SMAG trainers in the districts and health workers to be SMAG supervisors. ZISSP assisted with the formation of SMAGs in 10 of 27 target districts with a total of 1,046 (595 males 451 females) SMAG members trained from 53 of the 135 target health facilities. SMAGs are a GRZ program and other groups have been trained in other locations by different development partners such as PPAZ, UNICEF and UNFPA (including in some of ZISSP's focus districts). Developing plans to scale up SMAGs at the district and provincial level has not yet taken place in the districts that were visited by the evaluators. MNCH coordinators in the provinces and districts said they think that district-wide SMAG scale-up is important. The same informants said that all levels of SMAG training, including training of trainers (TOT), should be conducted at the local level. This may reduce costs and be more sustainable, especially if facility-based training is done.

[61] USAID comments, June 2013.
[62] Central Province Annual Statistical Bulletin, 2011. Published 2012.

By all accounts, SMAGs are implementing the training they have been given and receive support from the health facility to which they are attached. They use the data from their registers at the community level and provide it to the health facility. In the model site at the Namianga health facility in Kalomo, the data from the registers showed that the percentage of deliveries in the health facilities improved from 69.5 in 2012 to 78.0 in 2013. The percentage of deliveries at home in 2012 was 21.7 compared to 64.3 in health facilities (see Annex VII). SMAGs sometimes also provide volunteers to help out at the health facility and several of them include traditional birth attendants (TBAs) as members. Male involvement is considered a very strong component of the SMAG program that contributes to overall community support for safe motherhood. Some health facilities have seen a direct link between SMAG activities and increased health facility deliveries, but there are some questions about the reliability of data between SMAG registers and health facility data. Bottlenecks in aggregating health facility SMAG data and transmitting it to the district level were identified by SMAG program managers and a new reporting form was tested and released in April 2013. Although they were not yet available in the districts when the Evaluation Team visited, overall, the Team heard praise for the SMAG program from communities, health facilities, districts, provinces and from GRZ officials, DMOs, PMOs, MNCH coordinators, Provincial Nursing Officers, and health workers at health facilities where SMAGs are working.

Respondents to the Likert Survey rated the need for MNCH to be improved to attain planned targets as high, strongly indicating a perception that more effort is needed to reach national targets in this area. The survey did not break down MNCH into individual components (see Annex VI, Table 8).

Child Health

Respondents to the Likert Survey felt strongly that further reductions in child mortality were needed to achieve national maternal and child mortality reduction targets. This is a reflection of the shared priority in measures to improve child health services to meet this goal (see Annex VI, Table 8). ZISSP's PMEP focuses on training health workers and combines child health with nutrition. There are two child health indicators related to Vitamin A and DPT 3 coverage in the PMEP but no population-based surveys have been conducted related to child health routine services connected to these indicators. Surveys of this type are beyond ZISSP's mandate.

ZISSP provided training to provincial and district staff in the Reaching Every District (RED) in October 2012. The training included mapping where children under the age of one year live in the catchment areas and used community registers in collaboration with NHCs. The training emphasized "knowing the number of children, the amount of vaccines, and the costs of expanded programs on immunization ('micro-planning')[63]."

IMCI training has been provided for health workers throughout ZISSP's districts. Trainees are selected "by the district" but health worker selection criteria were not clear when DMOs were questioned. The Copperbelt Principal Nursing Officer (PNO) and MNCH focal person, and an IMCI health facility Master Trainer, said she knew that the mentorship program supported by ZISSP's Clinical Care Specialists included assessing IMCI skills but she was not clear about their role in supporting IMCI overall. Several integrated community case management supervisors that were trained are Environmental Health Technicians (EHTs). Their skills in promoting prevention behaviors and sanitation are superior and they do well performing IMCI assessments and treatments after training. It is not clear if GRZ considers EHTs to have sufficient clinical training to provide the necessary supervision for community volunteers on clinical treatment and the rational use of pharmaceuticals, and this requires clarification. Health human resource shortages mean that EHTs are often the only health workers available in rural health centers (RHCs)[64]. Lessons learned from multiple community case management programs in other countries and also experiences from the Bamako Initiative that have tried to address poor access to timely clinical treatment have shown that strong quality supportive supervision is essential when extending drug treatments outside of health facilities to improve access to treatment.

[63] See comments of data for decision making under "Cross-cutting"

[64] Core Group, Save the Children, BASICS and MCHIP, 2nd Edition, 2012: Community Case Management Essentials: Treating Common Childhood Illnesses in the Community, A Guide for Program Managers, Washington, DC.

Overall, routine preventive child health services have received relatively less attention in the ZISSP program in comparison to other technical areas. Coverage of the RED strategy is unclear and the impact after training was not reported in the districts visited by the Evaluation Team. MNCH managers believed that the RED training improved immunization service delivery but the Team could not find data to support that opinion. Health worker interviews and health facility registers reflect routine immunization although routine vitamin A and deworming are rare "except during Child Health Days," which are supposed to occur every six months but actually occur much less frequently. The pharmacist in Serenje district confirmed that zinc tablets, which are part of WHO's recommended treatment for childhood diarrhea, have been out of stock for at least five months. The pharmacist in Mkushi district said that zinc is usually supplied in kits but that the amount is insufficient to avoid stockouts[65]. When supplies of some drugs are low, the DHO must try to supplement them by using their own limited budget to purchase drugs on the open market. The Evaluation Team did not conduct an extensive review of vaccination practices or a complete review of drug and vaccine procurements, but the ZISSP Clinical Specialist from Southern Province said that BCG bottlenecks have been reported in her province and health workers' reluctance to open a vial of vaccine for "just one child" persists. Both are well-known causes of low immunization coverage. These issues should be assessed in more detail in the districts where routine child health services are supported.

Nutrition

Responses to the Likert Survey indicate a high priority for more efforts toward improving universal exclusive breastfeeding and other best infant and child feeding practices (see Annex VI, Table 8.) It is not clear if this relates directly to ZISSP's performance or to the overall high national priority placed on these activities by health professionals (see Annex VI, Table 8).

Training health workers and community volunteers in IYCF was a major nutrition activity of ZISSP but it did not appear to be well coordinated with its other activities. In fact, in Copperbelt Province, volunteers were selected and trained in catchment areas for health facilities not supported by ZISSP.

According to the KIIs with district nutrition focal persons, many IYCF volunteers were still waiting to receive counseling cards through the district because there were insufficient quantities provided in the training. IYCF volunteers were not provided with copies of the IYCF-specific reporting forms included in their training booklets, and have not been submitting them in many cases. They say they continue to submit the MOH forms that report on malnutrition detected in growth monitoring and promotion activities conducted in health facility outreach. Volunteers said they perform their work in communities, primarily during health facility outreach and growth monitoring and promotion but some provide nutrition talks during monthly Under Five Clinics. They also said that they conduct cooking demonstrations that promote locally available nutritious foods from information that they learned in IYCF training; and promote exclusive breastfeeding until six months, and porridge and similar foods starting at six months. However, they did not correctly answer questions about appropriate quantity and frequency of foods according to the age of the child, which is an important component of IYCF that is designed to prevent chronic malnutrition and stunting.

It is not clear why recommendations from the Baby Friendly Hospital Initiative (BFHI) Study that was published in December 2011 were not implemented shortly after the report was released. As of May 2013, BFHI activities had not yet started. When evaluators asked why, ZISSP responded that the report "just came out last year[66]." Evaluators were concerned that the delay might not allow sufficient time to implement, monitor and evaluate the impact of this important activity.

The Copperbelt Province Principal Nutrition Officer said she thought that while the IYCF community training was valuable, it was not linked to other activities in the province and not even to health facilities supported by ZISSP. In Central Province, the PHO also thought IYCF training was good but the "number of volunteers were few and the coverage is low[67]."

[65] KII with Serenje and Mkushi DHOs May 2013.
[66] ZISSP, June 2013.
[67] KII Interview, Central PMO, May 2013

ZISSP's Approach to Training

Based on presentations to evaluators, ZISSP views training as its key capacity building and systems strengthening strategy within all of the five technical areas and community health. ZISSP responds to training gaps identified by the MOH and many training interventions are a carry-over from previous projects (primarily HSSP) and a continuation of the same training strategies. ZISSP provides technical support to ensure that trainings are professionally structured, delivery methods are regulated, and standardized processes are in place for material development. In some cases, ZISSP has reviewed and strengthened existing materials; in other cases it has supported the development of new curriculum materials.

For most training that ZISSP conducts or supports, there is limited follow-up support, which may include post training visits, supportive supervision, coaching and/or mentoring. Some trained health workers on clinical care teams now serve as mentors. Through TOTs, ZISSP has helped develop a larger national pool of trainers for malaria, long-term family planning, adolescent health, IYCF, IMCI, and ZMLA. MOH or MCDMCH trainers, however, must juggle time demands of training with their other job responsibilities that often requires travelling from their usual place of work. Travel expenses contribute to high costs of training and supervisory visits, especially with recent increases in travel and training costs for trainers that come from GRZ.

Apart from skills based pre- and post-tests, there appear to be no measures in place that measure the results of capacity building progress within the MOH to manage trainings or training follow-up (especially routine supervision) activities once the ZISSP project ends. ZISSP has developed a "generic training program evaluation tool," which primarily measures participant feedback and only one component of training evaluations.

The GRZ's highly centralized training approval system takes time to navigate; this has at times affected the rate of ZISSP's progress (e.g. for the startup of the ZMLA and other trainings). Health worker mobility and attrition has resulted in the need to repeat some of the trainings. According to ZISSP, in-service training financial and opportunity costs are higher than when the project began. Mandated allowances for GRZ employees and fuel costs have both recently increased. Facility health workers that are assigned as supervisors and data collectors for community-based health volunteers frequently lack the skills and transport to effectively complete supervision and need additional support to be good supervisors. CHWs and CHAs lack drugs and supplies to provide the intended extension of health services but it is outside of ZISSP's mandate to address those challenges.

Capacity Building – CHA Supervisor Training

The WHO has urged national governments to develop cadres of paid health workers linked to the formal health system, in order to expand outreach and increase access and utilization of key health promotion and treatment services. In response to numerous challenges that Zambia has faced in the utilization of community-based health workers, the GRZ developed a more strategic approach towards community-based healthcare. Following the development of a National Community Health Worker Programme (NCHWP), the government, with support from partners, has since trained more than 307 CHAs, who graduated in mid-2012 and were then sent back to their communities. ZISSP supported salaries of the CHA tutors and the trained 220 CHA supervisors but does not have on-going activities with the CHA program.

The Evaluation Team assessed whether the CHA supervisor's training supported by ZISSP was effective. The Team originally planned to conduct one-on-one interviews with CHA supervisors and the CHAs themselves. It was found that while the Evaluation Team was in Ndola, all of the previously-trained CHAs were undergoing refresher training at the CHA Training School. The Team adjusted the planned methodology and developed a structured self-administered questionnaire (see Annex III), which was given to a total of 81 CHAs randomly selected and contacted through the dormitory caretaker. The results of the CHA survey are summarized below, and data and methods are presented in detail in Annex V of the report.

From the mini-survey results, it was found that CHAs had been working in the health facilities and communities for slightly over eight months, and since the time that CHAs were posted to their sites one out of every three CHAs reported that they had never received any[68] supervision visits. Of those that had received supervision, they had been supervised about three times in eight months. Most of those visits (60%) occurred between August-December 2012 (or more than five months before the evaluation). The CHA program requires CHAs to be supervised monthly.

Data from the CHA mini-survey corroborated information from the discussions held with DHOs, which included the DMOs and Designated District CHA Coordinators. They said that some districts sent the wrong staff to the supervisor's training. This was confirmed in a KII with one CHA Supervisor assigned to two CHAs that were also interviewed by the Team in Mkushi district. The supervisor said that he "was the wrong person to supervise CHAs as he could not travel to their sites and there was an enrolled nurse working at their health post who was a more appropriate supervisor."

The CHA Supervision Guidelines call for the Supervisor to visit the CHA at their sites, take back the completed tools, analyze the data, write a report with recommendations, and submit it monthly to the DMO. The report is also supposed to be shared during management and team meetings. The Evaluation Team found that very little, if any, of this was happening and DHOs were unclear about their responsibilities to support the CHAs, including providing kits and drug supplies. Several CHAs also said that they had not been paid on a regular basis and had not received kits as promised. In Kapiri District, only two of the six trained supervisors are still working in the jobs they had when they were trained.

CONCLUSIONS

ZISSP has contributed to building national level HSS capacity in multiple areas. Many activities have been completed or are near completion. Realignment of the ministries is unlikely to be completed before the end of 2014 and does not support developing new capacity-building initiatives in the limited remaining time. ZMLA training is very valuable and deserves support for expansion, probably beyond the resources available within the existing USAID projects currently supporting trainees.

ZISSP's systems strengthening for the GRZ at the provincial and district level is valuable, although more must be done to link the pieces together from the national level to the beneficiaries. ZISSP is providing capacity building, technical support, and coaching in several of the "building blocks"[69] but some activities are highly centralized (EmONC and IYCF), and sometimes GRZ officials say they are unsure about when planned training activities will be undertaken. Capacity building through management and leadership training provided by ZMLA goes a long way towards developing those linkages but numbers of graduates are currently small compared with the need and interest. Although ZISSP expects to reach its LOP target of 720, there are far more GRZ managers who need and want to be trained. If capacity and funds were available, the evaluators think that ZMLA training is a strong and sustainable HSS investment.

Based on the time elapsed and targets, ZISSP is somewhat behind in progress towards meeting the training indicators included in the PMEP. However, achieving targets for the sake of achieving them may not be desirable unless other health systems support is in place to allow trainees to practice what they have learned. ZISSP has trained large numbers of health workers and community volunteers in the technical interventions and there is evidence of improved health worker performance and increased outreach to key health services. Full effectiveness of these technical programs, however, is hindered by budget shortfalls, drug and equipment shortages, and limited capacity for supervision at the community level (see Issues for discussion at a level higher than the project).

HIV/AIDS activities are integrated in project activities and the most easily identifiable HIV/AIDs specific activities are within BCC activities at the community level. HIV/AIDS is part of clinical care mentoring and measured in QI activities but ZISSP could be doing more to link project interventions to support PMTCT, especially at the community and first-level health facility level.

[68] Whether from the trained supervisor or any other health worker.
[69] WHO HSS Framework, 2010.

Family planning activities are included in ZISSP, especially in the community health activities. Family planning services are also available in GRZ health facilities and included in the performance assessments that are the basis for the very popular mentorship components of the program. However, the integration of family planning with other services is not as extensive as the Evaluation Team expected given the importance of family planning in reducing maternal and infant mortality. Oral contraceptive supplies in districts and health facilities have decreased to the point where MNCH/Family Planning supervisors and pharmacists in four districts said that as of April 2013, they have reduced the number of oral contraceptive pill packs dispensed to each woman in health facilities from three packs to one per visit[70]. Long-term family planning equipment and supplies have not arrived for use for many trained health workers who say they are eager to begin providing these services.

Strong safe motherhood interventions implemented by multiple donors and development partners, including several USG projects, are showing impact in MNCH indicators but attribution directly to ZISSP's activities is challenging. Child routine preventive health services such as immunizations, vitamin A and deworming coverage need additional strengthening but the challenges are similar to those encountered in the other interventions.

Nutrition has been somewhat a standalone intervention and more effort is needed to integrate it into the other project interventions. Although ZISSP's technical managers see their role as "supporting the MOH programs," there are opportunities to integrate nutrition with other activities including PMTCT, family planning, and MNCH. Malaria activities are somewhat specialized and more coordination for case management and malaria in pregnancy with MCDMCH/MNCH programs is needed once the realignment of the ministries is better understood.

RECOMMENDATIONS

ZISSP should complete the ongoing capacity support to the MOH at the national level, and include sustainability and turnover of responsibility in its exit strategy. ZMLA training should be continued and ZISSP should participate with BRITE in the evaluation of the program to identify lessons learned for future programs.

ZISSP should increase technical support at the provincial level and focus most of its capacity building efforts on the districts for the remainder of the project to make sure that seconded staff is promoting the most recent evidence-based technical approaches within the GRZ health programs and the optimal amount of integration of technical interventions is achieved.

ZISSP should increase integration of family planning activities across all project interventions. Partner PPAZ should provide more technical support in family planning beyond two seconded staff. Assistance could also include providing direct technical support at the provincial level if human and financial resources would allow. PPAZ might be provided with additional funds to allow for technical support for family planning reviews of ZISSP's focus activities and advice on where family planning could be incorporated or expanded in existing project activities. Adolescent health should receive ZISSP's support from seconded staff able to build sustainable GRZ capacity. Planned CBD trainings should be revisited with regard to sustainable supply and supervision after the project ends and SMAGs may be better suited to this type of training.

ZISSP should strengthen HIV/AIDS activities through linking communities and households to increase PMTCT participation, follow-up on HIV exposed infants, and resume active participation in the PMTCT TWG. ZISSP should follow-up with all trainees from EmONC, FANC and IMCI, and collaborate with GRZ and other development partners to ensure that trainees have the supplies, equipment and supervision they need to implement what they have learned.

ZISSP should work with partners to strengthen the performance of CHA supervisors that were trained, and provide support for strengthening district level oversight of CHAs as part of annual planning and mentorship.

[70] Luanshya, Serenje, Mkushi districts.

ZISSP should strengthen promotion of breastfeeding and appropriate complementary feeding practices integrated in all programs. More effort at integrating IYCF and nutrition interventions with other project interventions should be done. Counseling card job aids should be provided to IYCF trainees that did not receive them. ZISSP should adjust its IYCF training strategies to correspond with the new national "1000 Days" initiative, follow through (as planned) with the BFHI study recommendations, and assist MCDMCH in making the shift from existing MOH nutrition policies and practices at the community level to the new approaches.

4.2.2 In what ways has community participation in health planning, implementation, monitoring and improving health practices in ZISSP target districts been strengthened?

Community Participation and Capacity Building

ZISSP's SOW describes a bottom-up approach to systems strengthening that engages communities in planning, supporting and delivering interventions and provides a link to the formal health sector[71]. Under Task 3: Improve Community Involvement in Production of Health in Targeted Areas, ZISSP supports effective health communication at the community level, promotes improved community health worker services for key health interventions, and strengthens involvement of traditional, faith-based and other opinion leaders as change agents for health. Evaluators looked for evidence in all of these areas.

ZISSP has supported community participation in health planning at the national level through: 1) a community health resources mapping exercise in 2011 to guide the planning of the project's community interventions; 2) a collaborative workshop with MOH and MCDMCH to develop a guide to engage district and health facility staff and community structures in community planning and subsequently developed the Community/Health Center Planning Handbook; and 3) revising the Community Health Planning Guide and developing a community health planning monitoring tool, community planning training materials, and community gender guidelines. Materials outline simple processes to develop community health action plans and ensure all community stakeholders - including women, men, youth, the disabled, traditional leaders, political leaders and people living with HIV/AIDS - actively participate in developing community health plans.

ZISSP's key strategy for health planning includes training 1,235 Health Center Advisory Committee (HCAC) and NHC members to reactivate committees, build community planning capacity, and strengthen linkages between NHCs and health facilities in 26 districts. According to ZISSP's provincial-level seconded Community Health Coordinators, these committees play a key role in mobilizing resources, including planning the use of 10% of health facility funding that is intended for community health activities. Some NHCs have been successful in accessing the funds, others have not.

Health communication programs have included BCC mapping, developing a BCC framework, and decentralizing BCC planning to district and community levels. ZISSP formed district and community BCC committees and produced manuals to teach them about conducting community dramas[72]. ZISSP also trained radio stations in malaria programming. Formative research was conducted on key IPTp health communication issues and a report was produced for MOH and stakeholders at the district level. 26 radio distance learning programs covering gender-based violence, male involvement, HIV/AIDS, hygiene, birth-planning, and alcohol abuse were developed. Provincial and district health promotion focal persons were trained and formed radio distance learning groups linked to SMAGs in three provinces. ACNM HBLSS materials and job aids primarily use pictures, which volunteers say are easy to understand and use[73]. ZISSP developed a toolkit, which is starting to be used, to orient traditional, faith-based and other opinion leaders with messages related to positive behavior change in five technical areas.

[71] ZISSP SOW p. 8.
[72] Training for Zambia Drama Groups in Community Theatre, A Trainers Guide, and Community Theatre Reference Manual for Drama Groups.
[73] SMAG FGDs, Luanshya and Serenje Districts, April - May 2013

Measuring behavior changes in target groups is not part of ZISSP's PMEP and many BCC activities had not yet been completely rolled out at the time of the evaluation. It will be very important for ZISSP to monitor the project's effects on recipient level of understanding of the desired behavior changes in order to determine if any barriers exist that may hinder behavior change.

ZISSP also developed a community grants program, supported by provincial and district grants support teams (GSTs), that is intended to strengthen community interventions to improve health outcomes across the five technical areas. A total of 144 applications from CBOs, NGOs and women-led community organizations were reviewed, from which 11, to date, have been selected and funded. Evaluators met with grantees in several locations. One grantee in Kalomo district, Southern province, trained a group of SMAGs in a remote area 45 km from a health facility with their grant. The grantee reported, however, that although it had submitted timely monthly reports, its second delivery of funds was delayed. This made it impossible to conduct supervisory visits or provide the volunteers with promised bicycles and other support materials. Evaluators noted that this group of SMAGs was younger and less experienced than other SMAGs, and had a particular need for supportive supervision and monitoring. Other grantees in Eastern, Copperbelt and Central provinces also reported delayed starts from the time when they signed their grants in August to the "launch" in November 2012 when their initial funds were released. Grantees did not know if their "one year" grants would end in August or November of 2013. At the time of the evaluation, more than $2 million in grant funds remained to be awarded.

Evaluators conducted FGDs with NHC and HCAC members trained by ZISSP in multiple districts and reviewed a number of community action plans, which were found to be well-developed. They also reviewed monthly reports at health facilities that listed specific health related objectives and activities such as promoting malaria prevention and treatment. NHC and HCAC members in the FGDs highlighted that their meeting facilitation and minute-taking skills are stronger as a result of ZISSP trainings. Some health workers in KIIs said that new planning skills have created a strong link between communities and health facilities.

> "Before the ZISSP training, NHC and HCAC members use to spend funds on non-community related activities such meals at meetings. But now we have seen a shift towards developing plans that that address issues at the community level. For example, one zone was able to build a toilet for the health post. We have also seen NHC mobilizing communities to come and clean the health facility environment (Health Worker, Munyumbwe Rural Health Center)."

ZISSP supported the establishment of BCC district coordinating committees that are intended to promote key health behaviors; however, the Evaluation Team was told by DMOs that the committees were generally not active after the training due to lack of funds. Other community health volunteers such as NHC members did not appear to know about these committees or their purpose. The ZISSP CHC said that after training members of BCC committees (usually members of other organizations) it was expected they would conduct activities using their own resources, although this apparently was not well understood.

ZISSP's support for training CHA supervisors has been addressed elsewhere but also contributes to the "support of improved community health worker services for key health interventions[74]."

ZISSP supported MOH and MCDMCH to train SMAGs in 16 districts, using 12 modules adapted from ACNM's Home-Based Life Saving Skills (HBLSS) curriculum. This content is nearing approval as the GRZ national SMAG training curriculum. SMAGs mobilize communities to address family planning, safe pregnancy and delivery, newborn health, and increasing male involvement in all of these activities. Evaluators found that the traditional and faith-based leaders mentioned earlier are frequently also members of SMAGs, NHCs and HCAC, and were therefore also closely engaged with target health facilities and monitoring health interventions in their communities.

> "I conduct visits to the health facilities during ANC to check on how many women come with their spouses and I follow up with those that do not heed to the call for couples testing together. I also follow-up on cases of home deliveries and those that deliver at home are made to pay a fine of a goat (Traditional leader/Chief, Sinazongwe district)."

[74] See Community Health Assistant Supervisor Training in Capacity Building

Community Health Information Systems

In April 2013, a new data collection tool was developed to improve the flow of SMAG data to the DHO. It had not yet reached the districts when the Evaluation Team conducted their visits. SMAGs keep detailed records of pregnancies, number of ANC visits for each mother, pregnancy complications, home and health facility births, birth outcomes, and post-natal care. Evaluators were impressed by both the qualitative reports and quantitative data provided by SMAG volunteers, especially given common assumptions that low education levels mean that community volunteers' capacity to collect, record and report information is limited. The level of performance from data indicates that SMAGs are effective in increasing male involvement in increasing couples' HIV testing at first ANC visit, women attending ANC earlier, promoting more open communication between partners about birth planning, recognizing danger signs during pregnancy, supporting pregnant women at home, and providing assistance for mothers to make use of maternity waiting homes (that have been constructed close to health facilities) near the time of delivery to promote increased institutional births and post-natal care. Globally, health and nutrition volunteers that are strongly linked with a health facility receive consistent supervision and have resource materials that are known to outperform those that do not[75]. The Evaluation Team is concerned that not all groups may be experiencing the same level of support. Overall, SMAGs appear to be the most effective behavior change agents operating at the community level under ZISSP.

SMAGs say they use the information collected in their registers to inform the community about activities and monitor family actions. The Evaluation Team conducted FGDs with and reviewed the registers of SMAGs in several districts in multiple provinces and was impressed with the quality of monitoring conducted by the volunteers. Entries in the SMAG registers assessed for quality were found to be nearly complete. However, registration dates for pregnant women were missing except in the registers at the Namianga SMGL site.

This above information is reported monthly to SMAG supervisors at health facilities and is reconciled with health facility registers. Issues of data quality are currently being addressed by ACNM and other partners. The evaluators looked at some data and surmised that pregnant women may be under-registered in some age groups. An expanded analysis of the quality of the SMAG data for assessing coverage and outcomes of the pregnancies monitored by SMAGs is shown in Annex VII. This data was shared with ZISSP and the Evaluation Team encouraged them to monitor the consistency of registration of all beneficiary mothers.

NHCs are also directly engaged in helping communities engage in practical malaria prevention activities such as dumping standing water sources and promoting use of rapid diagnostic tests when available[76].

CONCLUSIONS

The Evaluation Team was enthusiastic about the quality and effectiveness of the SMAG and NHC trainings that ZISSP has conducted. Both groups have the potential for sustainable impact at the community level, especially linked with the community development and income generating activities (IGA) implemented by other partners. The BCC activities and community grants programs have not yet been fully implemented and their coverage is not large so the Evaluation Team thought that it was too early to judge their impact.

RECOMMENDATIONS

Current support to train SMAGs and NHCs should continue. ZISSP should work with districts that want to scale up these activities to other communities in order to include them in the planning. ZISSP should also consider meeting CBD training targets by including experienced SMAGs in the training to become CBDs. For sustainable support, ZISSP should help link community groups that have received capacity building through the project with the MCDMCH by providing information about where the district MCDMCH offices are located.

[75] Core Group, Save the Children, BASICS and MCHIP, 2nd Edition, 2012: Community Case Management Essentials: Treating Common Childhood Illnesses in the Community, A Guide for Program Managers, Washington, DC.

[76] Rapid diagnostic test (RDT) stockouts, however, were reported at nearly every community meeting and health facility visit during the evaluation although DHO records indicate that up through early 2013, RDTs were available.

4.3. HUMAN RESOURCES FOR HEALTH (HRH)

4.3.1 In what ways has the MOH's capacity to attract and retain health workers in rural positions improved?

ZISSP started in 2010 when the National Health Strategic Plan (NHSP) and NHRSP were developed. Although a health stakeholder analysis concluded that, as of 2007, Zambia had succeeded in reducing maternal and child mortality rates,[77] further progress towards achieving the MDG was hampered by severe HRH shortages and limited health worker capacity. Many attempted interventions have not been successful due to these shortages as well as multiple other factors including poor service conditions, unsatisfactory working conditions, inequitable distribution of staff between urban and rural areas, weak human resources management systems, and inadequate training systems[78]. ZISSP's reports indicate that of the estimated 60,000 needed health workers, only 34,000 positions were filled as of September 2012. These low numbers were exacerbated by GRZ's mandatory retirement labor laws that forced some of the most experienced health workers out of the system, including many recently-trained health workers. On May 29, 2013, the Zambian national media reported that GRZ had just raised the civil service retirement age from 55 years to 65 years[79] and it is too early to tell how this change will impact the health workforce.

ZISSP's HRH activities primarily contribute to two GRZ NHSP objectives: 1) provide cost-effective, quality and gender sensitive primary health care services to all as defined in the Basic Health Care Package[80]; and 2) improve the availability and distribution of qualified health workers in the country[81]. ZISSP's initial analysis conducted with MOH and other partners found that health worker shortages were exacerbated by the limited capacity of training institutions to produce the required numbers, high turnover (including rotations), and inequitable distribution. It also found inadequate human resource management capacities such as weak staff supervisory skills, monitoring of staff absenteeism and staff deployment, and an inadequate HRIS, all of which make it difficult to effectively undertake personnel planning. In addition, there were weak accountability structures and performance management systems[82].

Technical Support to National MOH HRH Office

ZISSP has provided support to the MOH HRH to:

1. Adopt job-based training and mentoring programs to build human resource management (HRM) capacity in provinces and districts that includes capacity building in HRM, planning, and records management
2. Assess staffing needs based on the WHO protocol of Workload Indicators for Staffing Needs (WISN). ZISSP trained 80 provincial staff - 41 males and 39 females - on the WHO-designed WISN tool as a step towards developing better health workforce plans[83]. Starting in 2013, a pilot on implementing the WISN tool is being conducted
3. Develop a modern HRIS building on existing foundations
4. Strengthen the payroll management and establishment control (PMEC) system and develop prototypes for needs based HRIS for MOH
5. Support development and roll-out of effective policies and systems to attract and retain staff and enhance staff productivity – specifically, support the ZHWRS
6. Support the implementation of the new GRZ Performance Management Package (PMP) and staff appraisal system to improve health worker performance. PMP is a system for accountability and development of management skills for the health sector. The PMP introduced the new GRZ staff to the Annual Performance Appraisal System (APAS), which replaced the old Annual Confidential Reporting System, and which will cover all staff and is based on individual work planning and target setting for improved staff performance.

[77] Zambia DHS 2007
[78] National Human Resources for Health Strategic Plan, January 2012
[79] Zambian National Broadcast Corporation, May 29, 2013
[80] National Health Strategic Plan, 2011-2015
[81] Ibid.
[82] ZISSP briefing to MTE team, April 2013.
[83] ZISSP briefing to MTE team, April 2013.

ZISSP conducted a capacity needs assessment for the HRH Directorate that identified weaknesses and possible solutions for improving GRZ HRH systems. It also trained MOH HR staff, records management staff and registry clerks in HRM planning and records management. The MOH has since purchased computers for the Registry Department at HQ for an electronic file tracking system to be rolled out to provinces.

4.3.2 What are the perceptions of health workers who are currently on the ZHWRS about how effectively it is managed?

ZISSP had two specific, but limited roles related to ZHWRS. The first was to provide one seconded staff at the national level to provide administrative support to the program. The other was to provide reimbursement to GRZ for allowances for a limited number of health workers on the scheme. As of 2013, ZISSP provides reimbursement to the GRZ for the rural retention allowances of 119 out of the total 1,061 health workers covered by the ZHWRS. In an interview with the Evaluation Team, the Director of HRH reported that the MOH had thought ZISSP would take up more than 119 employees and was disappointed that this has not happened (according to USAID, the number was agreed upon when the MOU was signed with MOH). The MOH HRA Directorate[84] must make payments from their own funds up front and then seek reimbursement from ZISSP, which takes time. The Director expressed unhappiness that this arrangement requires HRA to borrow from other budget line items to advance the payments[85]. ZISSP seconded a full time administrative staff person to the ZHWRS within the HRA Directorate to manage the scheme and build management capacity. This person left in 2012 and was not replaced. ZISSP's Deputy Chief of Party told the Evlauation Team that the Directorate informed them that a replacement was not needed because the office now had the apacity to manage the program[86].

MOH managers at the national, provincial, and district levels, as well as health workers supported by the ZHWRS, said that the scheme is contributing to the GRZ's ability to attract and retain health workers in rural areas. Some respondents told evaluators that the retention scheme incentives had encouraged them to upgrade their qualifications in order to be eligible for a higher level of scheme incentives.

The score on the Likert Survey directly related to the question indicated that there is a perception that the scheme does help attract and retain health workers. This was corroborated by KIIs with health workers on the scheme. However, respondents to the survey reported several management problems in the program and this was confirmed by interviews conducted during the field visits. Most of these issues have nothing to do with the ZISSP program but reflect on the continued management capacity limits of the program (see Tables 3 and 4 in Annex VI). No records are available to verify or quantify the number of health workers who are actually attracted and retained in remote, rural settings specifically due to the ZHWRS. Health workers on the scheme also said that additional incentives such as housing, new medical equipment, and car loans are not always provided or are limited to certain health worker cadres. GRZ representatives in districts told the Evaluation Team that there were differences in their understanding about how the program was supposed to work, including whether additional health workers can be placed on the scheme. Some district health workers and DMOs have been told that all slots have been filled, while in other districts health workers are still encouraged to apply[87].

Some health workers said that they found it impossible to monitor the accuracy of payments to them as both payment amounts and timing were inconsistent. Payments are difficult to track because they are wired directly into bank accounts and not attached to pay slips. Most health workers interviewed, however, said that while payments have come late, eventually they do receive catch up payments[88]. The time for eligible health workers to be placed on the scheme varies considerably from one month to one year. One health worker said her colleague was transferred out of her position after one year without ever being put on the scheme, even though she had applied promptly[89]. Health facility eligibility criteria

[84] At the time of the ZISSP MTE, this authority was in process of transfer to the MCDMCH.
[85] Key informant interview with MOH HRA Director, April 18, 2013.
[86] Personal conversation with ZISSP Deputy Chief of Party, May 2013.
[87] Interview with Gwembe HRO.
[88] Interview with health worker in Sinazongwe.
[89] Interviews in Gwembe and Sulwegonde rural health center in Kalomo District April 2013).

also do not appear to be consistent. The Evaluation Team met with health workers in remote areas who were previously on the scheme in similar remote areas but not deemed eligible in their new locations[90]. Transportation support, improved accommodation, and access to communication[91] were identified as important incentives.

Many health workers reported that management of the scheme deteriorated after the ZISSP seconded staff member managing the scheme left. HR officers in the districts said that they assist health workers to apply but cannot troubleshoot when problems arise. DMOs said that that if DHOs had a more active role in managing the scheme, they could ensure that the correct health workers are posted to eligible health facilities and would know which health workers are covered by the scheme. At the time of the evaluation, ZISSP was conducting an assessment to determine how well the retention strategy is working. The results will be available later in 2013.

CONCLUSION

In the Likert Survey, GRZ and ZISSP staff confirmed perceptions that the Evaluation Team found in KIIs including that: 1) ZHWRS is helping to retract and retain health workers in rural areas but there are gaps in coverage of the needed number of workers; and 2) the overall program has management problems that have worsened since the ZISSP seconded staff person left. ZISSP's role in the program is limited and addressing problems in the program is a higher level issue. Most of the comments in the evaluation report are related to the overall program. If anything, ZISSP's assistance through the seconded staff person helped the program to run more smoothly than was the case at the time of the evaluation. Addressing weaknesses in the overall ZHWRS is beyond ZISSP's mandate.

RECOMMENDATION

ZISSP should offer to replace the seconded staff member at ZHWRS, preferably with someone with sufficient capacity building skills for sustainable and effective management of the program after ZISSP ends. The evaluators recognize that this is a GRZ decision and that this recommendation may not be accepted.

4.4 COORDINATION AND INTEGRATION

4.4.1 In what ways has coordination and synergy of HIV/AIDS, MNCH, Nutrition, Family Planning, and Malaria services provided by stakeholders in ZISSP target districts been strengthened?

ZISSP collaborates with other partners through mechanisms already in place. Activities include:

- Provision of technical leadership and an organized platform through national TWGs
- Participation in USAID partner meetings and interagency coordinating meetings
- Support of activities of provincial HIV/AIDS Coordinating Committees
- Participation in annual health planning and review processes

Partners specified in the SOW for engagement, coordination and integration include ZBSCCP (the original name for the USAID project, now known as CSH, or Communications Support for Health), ZPCT II, CIDRZ, CARE International, CHAZ, UNICEF, MACEPA, SIDA, and GFATM[92]. ZISSP also collaborates with the Center for Disease Control (CDC) and other USG partners. PMOs also mentioned situations where ZISSP stepped in and completed trainings that other partners were unable to complete.

The Likert Survey responses from both GRZ health officials and ZISSP seconded staff gave high scores in all fields related to this question, indicating a perception that ZISSP is doing very well in this area (see Annex VI, Table 5).

[90] Munyumbwe rural health center, Southern Province.
[91] Mobile phone reception or two-way radios.
[92] Zambia Behavior and Social Change Communications Program, Zambia HIV/AIDS Prevention Care and Treatment Partnership, Center for Infectious Disease Research in Zambia, Churches Health Association of Zambia, United National Children's Fund, Malaria Control and Evaluation Partnership in Africa, Swedish International Development Agency, Global Fund for AIDS, TB and Malaria.

ZISSP's senior managers say that their engagement with GRZ and other stakeholders is primarily through several TWGs and the products (policies, guidelines, and training materials) that have emerged from these engagements are well documented in annual and quarterly reports. Other implementing partners reported that they were very involved in the HRH TWG and IRS TWG but didn't think ZISSP had been active recently in the PMTCT TWG.

According to the MOH and MCDMCH, ZISSP seconded staff at the national level has provided valuable technical support to improve functions in multiple areas including HRH, health accounts and performance assessments, and in technical areas.

ZISSP supported the national SMGL initiative by seconding staff for one Provincial Coordinator (Eastern Province) and four District Coordinators in Kalomo, Mansa, Lundazi and Nyimba. This staff coordinates work of all SMGL partners and produces monthly partner activity reports. Coordinators also provide technical support, including clinical mentoring and supportive supervision with partners for safe motherhood activities such as maternal death reviews and SMAG training and supervision. If GRZ approves the SMAG curriculum developed by ACNM under ZISSP, it would demonstrate country ownership.

ZISSP has not only participated in target provinces' and districts' annual health planning and review processes but has also provided some of the financial and technical support to make these activities possible. This is one of the key areas where evaluators consistently heard praise for ZISSP's capacity building and an area where the readiness of PHOs and DHOs to continue partners' meetings after ZISSP ends needs careful monitoring.

ZISSP collaborated with other partners (e.g. Elizabeth Glazer Pediatric AIDS Foundation, CIDRZ, and CARE International) for joint trainings and TOT workshops, and with government (MOH and NIPA) trainers to build a solid foundation for new training courses and, toward the same end, trained many GRZ counterparts as both clinical and ZMLA mentors. The CDC expressed disappointment that it has not yet been able to develop a synergistic relationship with ZISSP for the development of a joint QI training curriculum and strategy.

Grantee organizations funded by ZISSP in 2012 have been encouraged to coordinate and integrate with other local partners for BCC activities and materials distribution.

Opportunities to explore PPPs as planned in the original SOW were not developed. This was based on a USAID decision not to go forward with Banyan Global's partnership role in ZISSP because another USAID-supported PPP project was already underway in Zambia. However, there are new opportunities for collaboration with MCDMCH and their NGO partners to help sustain community structures built up by ZISSP, such as the SMAGS, NHCs and BCC groups through MCDMCH's community development programs implemented with other development partners[93].

CONCLUSIONS

The Likert Survey and KIIs with partners confirm that ZISSP's integration and coordination is taking place at almost every level in terms of partnerships and joint activities. There appear to be more opportunities to integrate technical interventions and this report has pointed to several of them.

RECOMMENDATIONS

Successful integration of ZISSP's capacity building investments needs to be supported through partners that support sections of HSS that are not part of ZISSP's mandate. ZISSP should continue to engage senior managers in high level partners' meetings with the GRZ, especially the ICC and the Joint Annual Review, and increase senior management participation in the TWGs related to project interventions. ZISSP seconded staff at the national level should increase their presence in the offices they support.

[93] Comments from MCDMCH representatives on the MTE team, April and May 2013. One example of another development partner working at community level would be the Heifer Project that is working in animal husbandry with one group of SMAGs in Luanshya District.

In addition to continuing to attend the high level meetings at the national level already mentioned, ZISSP should actively engage in partner and stakeholder meetings (such as TWGs) to address supply chain and equipment problems in health facilities where health workers trained by ZISSP are working. ZISSP should coordinate with the CDC for QI trainings.

Although ZISSP says it participates in the PMTCT TWG, it was not on the list of TWGs provided to the evaluators and one partner that is active says they have not seen them participate. Whether or not these perceptions are real, PMTCT is a logical area for strong and active participation to support activities that integrate several ZISSP focus areas.

4.5 COUNTRY OWNERSHIP

4.5.1 What is the perception of MOH and NMCC regarding ZISSP seconded staff's role in building capacity of GRZ counterparts to plan, design, implement, manage, monitor and evaluate health programs at the national, provincial and district levels?

The evaluation question relates to country ownership focused on GRZ's perceptions regarding the ZISSP seconded staff's role in building GRZ health program capacity at multiple levels. The Likert Survey and KIIs were focused primarily on that question. Both GRZ officials and ZISSP seconded staff rated performance in this area to be high (see Annex VI, Table 6).

KIIs with GRZ health officials confirmed the Likert findings that ZISSP's seconded staff at the national, provincial and district level are highly regarded and their contributions are appreciated. ZISSP assisted the MOH to develop, complete and roll out many studies, policies, strategies, guidelines, training strategies, and action plans[94]. Some of these documents were started in the predecessor project, HSSP (also implemented by Abt Associates), but were completed under the ZISSP project. These activities are largely finished, with a few still to be "rolled out."

Technical assistance provided through a consultant to the MOH Budget and Planning Office helped them to "catch up" on reconciling the National Health Accounts. Aside from assistance with one more two-year review, those efforts are largely completed and that office says it will continue without external support[95]. Introduction and assistance with performance assessment review tools and guidelineshas been tremendously helpful to the MOH Directorate of Technical Support Services staff, who say that approval and institutionalization of these tools is anticipated soon. Once approved by GRZ and "launched," they become official GRZ policy and are institutionalized.

In 2012, ZISSP updated the malaria M&E tools, including the Needs Assessment Checklist and Monitoring and Supervision Checklist used for data collection at the district level. This contributed towards ensuring that data for IRS planning were available on time. In 2013, ZISSP will support NMCC to review malaria M&E tools for monitoring and supervision and to conduct a needs assessment. ZISSP will also support NMCC to conduct district malaria data audits in 12 health facilities in four districts. The malaria databases on ITN distribution and IRS spraying will also be updated and reviewed. ZISSP will also conduct an IRS impact study, which will build on a 2011 Ndola study of malaria positivity trends. An NMCC official said at the evaluation stakeholder's meeting that his office intends to absorb the M&E position currently filled by a ZISSP seconded staff person.

As of 2013, ZISSP is operational in supporting IRS programs in 20 districts. In 2010, ZISSP managed IRS in 37 districts to help fill a national short term gap in services. ZISSP led the revision of national malaria guidelines and included malaria prevention and case management in health worker trainings. ZISSP is also involved in active infection detection in Lusaka district and employs entomologists and epidemiologists in ongoing resistance detection. The project sends laboratory specimens to one partner, as part of its research into emerging insecticide resistance and changes in the overall malaria epidemiologic patterns in Zambia.

[94] See full list as of May 2013 provided by ZISSP in Annex IX
[95] KII Deputy Director, MOH Directorate of Planning and Budget, April 2013

CONCLUSIONS

The evaluation question regarding country ownership was limited to GRZ's perceptions about ZISSP seconded staff's contribution to GRZ health system capacity. ZISSP has made significant contributions through partner collaborations in several components of HSS at the national level, and seconded staff are a large part of that contribution.

Unavailability of many of the key GRZ officials to respond directly to the broader country ownership issues precluded the Evaluation Team from commenting without validation from the GRZ officials themselves, which might have been interpreted as conjecture. Evaluators agree, however, that there appear to be many areas where progress toward country ownership might be identified and the contributions to the NMCC require a more thorough assessment than could be done during this evaluation.

RECOMMENDATIONS

ZISSP should develop a detailed exit strategy and sustainability plan in dialogue with GRZ for turning over project activities that are intended to be sustained after the project ends. As part of its exit strategy, ZISSP should include specific plans to determine if any of the functions of current seconded staff will be absorbed into the GRZ systems. Contributions to the NMCC should be documented. Part of this turnover strategy should include sharing information about the actual costs of activities that ZISSP has been supporting to help the districts and provinces plan and budget for those activities that they want to sustain. If USAID would like to document the broader issues related to ZISSP's contributions to country ownership, then USAID and ZISSP should do this jointly, perhaps using the USAID country ownership matrix that was developed for this purpose.

ZISSP's support for informing and training SMAGs and NHCs should engage the MCDMCH community development officers to develop linkages for sustainable support to these groups and their activities after the program ends. ZISSP should also expedite the award of the remaining community grants so they will be completed before the project ends.

4.6. GENDER INTEGRATION

4.6.1 To what extent have women been empowered to take action in support of health behaviors and interventions in ZISSP target districts?

The ZISSP PMEP has no indicator that specifically measures the extent to which women have been empowered to take action in support of health behaviors and interventions in ZISSP's target districts. The Likert Survey responses similarly related to broader gender issues. The Likert Survey question regarding acceptance of women's leadership in community structures scored 5.76. This indicates perceptions that there is slight progress in the area addressed by the question, but not enough to declare that efforts are successful at this stage of the project[96] (see Annex VI, Table 7). ZISSP's project strategies include focus on both genders. Male involvement in safe motherhood, for example, is highlighted in many areas where men have been identified as barriers to women receiving health services and information. Training reports are also disaggregated according to gender.

At the national level, ZISSP provided support to conduct a gender analysis study to help the MOH develop a National Gender Strategy[97]. In 2012, ZISSP conducted a gender analysis of two districts in Muchinga and Lusaka Provinces to identify barriers and factors to enable access, utilization and demand for health services among women, men, and youth, and inform policy and mainstream gender in all health activities. The report's results were presented to and adopted by the MOH before dissemination to PHOs and DHOs as a resource document for the planning cycle. The MOH Gender Strategy was released in 2013[98]. During the first CHA training in 2012, ZISSP oriented participants on the role that gender plays in the demand for, access to, and utilization of health services that culminated in the formation of a school gender club with membership that included all 292 CHAs and their tutors. ZISSP also has its own gender strategy.

[96] Any score over 5.0 would be considered "progress" but and overall score over 8.0 would be needed to be considered "successful".

[97] GRZ Ministry of Health Gender Strategy 2013.

[98] The Zambia Integrated Systems Strengthening Project Gender Strategy, June 2012.

Neither the MOH nor the ZISSP gender strategy specifically address women's empowerment in health and ZISSP's approved PMEP does not include indicators or targets that specifically address increases in female empowerment in health.

ZISSP's gender strategy from 2013 is an in-house document which defines female empowerment but does not explicitly state how this will be accomplished through ZISSP's interventions and does not include measurement indicators. Activities under "gender" in the document include support for the MOH's gender analysis study and dissemination of the results, sensitization of health workers, and promotion of male and female participation in annual planning at community levels through building capacity of NHCs in planning skills.

The gender analysis study, however, acknowledges the importance of encouraging women's participation in health planning, promoting women's decision-making in health facilities and, at the community level, challenging gender norms that encourage home deliveries, etc.

In project documents and briefings to the Evaluation Team, ZISSP senior managers said that they have made every effort to ensure that all supported trainings reflect gender balance among participants. This has been challenging for a variety of reasons and the ZISSP PMEP data, broken down by gender, confirms that there is still more to be done. Out of a total of 11,339 sex-disaggregated training data, the male-female ratio for trainees was 6 to 4[99]. ZMLA trains more men than women presumably because more GRZ health managers are men. Facility and community project training data are also usually disaggregated by gender. The HMIS data collected in most ZISSP target districts, however, is not disaggregated by sex and the GRZ data collection tools are not structured for this purpose. District data is also not disaggregated, so gender analysis cannot yet be included as part of district planning. ZISSP is planning to develop a data quality audit guideline which will standardize the data quality audit process to assess indicators that do not seem to be well understood by health workers. From this analysis, ZISSP will determine whether gender-related data can be collected using existing data collection tools.

> "I chose to become a SMAG member because I knew that my leadership authority would move the safe-motherhood agenda forward. Women or couples would easily follow instructions to deliver at a health facility if commanded by a headman (Headman in Mkopeka)".

The Evaluation Team observed balanced participation between men and women in SMAG membership/training data and activities. The Likert Survey and KIIs found that there are perceived increases in the number of women volunteers taking on leadership positions in the SMAGs and NHCs as chair persons, secretaries and/or treasurers. Increased male involvement in safe motherhood through the SMAG program - including male participation as SMAG members, with male traditional leaders (chiefs and village headmen) providing leadership in encouraging and assisting women to participate in safe motherhood activities - was also in project reports and observed during the site visits. SMAG members also reported that more couples are now tested together for HIV during ANC. The radio distance-learning program is being integrated into SMAG activities, as well as some activities by BCC committees formed by ZISSP with the objective of increasing women's participation in their own health care supported by their families and communities.

CONCLUSIONS

ZISSP's five program strategies include a gender focus but not specifically a focus on "women's empowerment to take actions in health," and there are no indicators in ZISSP documents or their approved PMEP to measure it. The MOH Gender Strategy was just completed in 2013. It is not clear if the women's empowerment focus from USAID has been clearly communicated to ZISSP.

RECOMMENDATIONS

If women's empowerment to take action for health is supposed to be a specific ZISSP focus, USAID should clearly instruct ZISSP to implement strategies targeting those outcomes, report on them, and include measurements in the PMEP. ZMLA training content should be reviewed to ensure that gender focus specifically includes women's empowerment to take action in health. ZISSP might be able to find additional

[99] For details please see Annex: VII ZISSP Training Achievements against Targets

opportunities to strengthen women's empowerment in health within their existing activities but major additional activities might require a change in ZISSP's program description if USAID so intends.

4.7 CROSS-CUTTING: PLANNING AND USE OF DATA FOR DECISION-MAKING

Planning and systems strengthening support for the GRZ at all levels has been a major focus for ZISSP in its SOW, annual work plans, and documented in its annual reports. ZISSP says that it has updated existing planning materials and developed some new ones and that the process of jointly developing these materials with the GRZ has always been slow. This has been especially true during the realignment of the ministries. ZISSP also printed and distributed 5 planning handbooks for MOH-HQ/provincial offices, districts, and statutory boards, hospitals, training institutions, health centers and communities[100]. ZISSP collaborated with MOH and MCDMCH to prepare for the 2013 annual planning cycle[101]. The project also provided support to the MOH through a sub-contract to the University of Zambia, Department of Economics, to produce NHA and to train MOH personnel in health economics. The Deputy Director of the MOH's Office of Planning and Budget said that the ZISSP consultant's assistance in updating the health accounts has helped them update several years of accounts to the point that once an additional review is done after two years have passed, they will have the skills to manage them well on their own[102].

ZISSP also assisted the MOH and MCDMCH to develop a guide to better engage district and health center staff and community structures in community planning[103], and printed copies of community health planning materials that were developed in earlier USAID-supported projects[104].

ZISSP reported that in spite of the availability of planning handbooks, program managers still had challenges in developing their action plans; therefore, ZISSP provided technical and financial support for the MOH to develop guidelines which provided step-by-step processes for action planning. These guidelines are being finalized for use during the 2013 planning cycle for the 2014-2016 medium-term expenditure framework period.

ZISSP also provided support to MOH in information management at the national level to strengthen data quality and usage in decision-making processes and planning. However, evaluators observed, and ZISSP senior managers confirmed, that ZISSP provides no technical support to the national HMIS[105]. They also developed a gender analysis report (described earlier) for use by PHOs and DHOs during planning cycles. ZISSP supported production and publication of 2011 provincial statistical bulletins that used HMIS epidemiological data to develop the Annual Plan for 2013. They also developed and implemented a tool for provincial planners to compile routine data for NHA. Technical assistance was provided by Abt Associate's Global Health Systems 20/20 project (HS20/20) to assist the MOH in adapting the marginal budgeting for bottlenecks (MBB) tool for district level planning needs[106] that USAID said was piloted in six districts last year[107].

A few health workers have been offered ZMLA training to support them in district planning. Major project activities have included revitalizing NHC/HCACs, orienting health workers to their roles and responsibilities, and training them in planning. This training provided health workers with the capacity to develop their own annual community action plans and integrate them with the health facility and district

[100] Provincial Health Office/MOH-HQ Planning Tool, Statutory Boards Planning Tool, Hospital Planning Tool, Training Institutions Planning Tool, and Health Center/Post and Community Planning Tool.
[101] (MOH to concentrate on provinces, level 2 and 3 hospitals, statutory boards and training institutions per their new mandate. MCDMCH to spearhead the district level planning process with guidance from MOH).
[102] KII wit Deputy Director, MOH Planning and Budget Office, April 2013.
[103] The guide outlines the process that ensures that all stakeholders including women, men, youth, the disabled, traditional leaders, political leaders and People Living with HIV/AIDS actively participate in developing community health plans.
[104] These materials were initially developed by ZIHP/CBoH and later updated by HCP/MoH the reprinted by ZISSP.
[105] Interviews with ZISSP COP and Deputy Chief of Party, May 2013.
[106] [106] ZISSP Annual Report and briefing to MTE team, April 2013.
[107] USAID Comments, June 2013.

annual plans. Interviews with NHCs conducted during the evaluation fieldwork confirmed that the NHCs that received training are implementing what they learned, some more effectively than others.

CONCLUSION

ZISSP's contributions to strengthening both planning and management are likely to have lasting and sustainable positive impacts on Zambian HSS, especially if sufficient resources are provided for managers to implement their plans and new management skills.

RECOMMENDATION

ZISSP should continue to support the planning and management activities it is implementing at the provincial and district level. It should also document management lessons learned in the project to share with USAID and other development partners to be used for planning future programs. It would be beneficial if long-term development plans would include institutionalizing ZMLA, possibly inside NIPA, if resources are available. Discussions about how to adjust plans and prioritize activities when funds received by the district are significantly less than budgeted should also be included. Contingency planning might help to avoid cut-backs on the activities that are contributing the most toward improving access and utilization of health services and information.

Data for Decision-Making Challenges

Zambian public health professionals stated that problems with the HMIS have been around for a long time. DMOs and DHOs said that data generated by the system, which is facility-based and only analyzed several months after it is generated, is not readily available for making timely management decisions. Unclear management roles of those who are responsible for management of the data contribute to the difficulties that district health teams experience in using the HMIS for planning and managing health services. This can result in the DHOs being unaware that important events such as maternal or newborn deaths have recently occurred in their health facilities or inaccurate data being transmitted into the national HMIS. For example, the staff member responsible for HMIS data entry at a designated "model site" incorrectly entered three maternal deaths from malaria in early 2013 when there were actually no maternal deaths[108]. The error was eventually caught by the DMO, but it highlights how poor quality data can easily be included in the system. It is not known if the newborn death attributed to tetanus that happened in early 2013[109] in Serenje district was really a tetanus case. If so, it could be an important indicator of the overall system's weaknesses that the DMO would want to address; however, the information was not readily available for action. It should be noted that the facility in question was not one of those supported by ZISSP but belongs to a ZISSP-supported district[110].

> "It is like being told you have only five people in your house and given money for food for that number when you really have 19 people; no wonder our drug stocks run out in the middle of the month (Acting Planner, Kapiri Mposhi)."

Overall, public health planners at the district level do not trust "official" population estimates that are generated and published by the Central Statistical Office (CSO) based on extrapolations from census data that must be used as the basis for planning, budgeting and ordering drug stocks. At the PMO and DMO level, health officials have more confidence in population figures generated during community health activities such as immunization campaigns or IRS district household mapping.

Review of HMIS data in districts visited during the evaluation revealed declines in some indicators of performance challenges where the DMOs suspected there were problems but did not have current data to confirm what they had thought (see Annexes IX – XI for graphs of district HMIS data collected during the evaluation). Districts are required to plan activities using budget figures in the "Yellow Book" of the national budget and are left trying to implement plans that are underfunded when the district does not receive all of the funds indicated. Normally, DMOs say the first activities to be cut are outreach and supervision, which are key elements to achieving increased access and utilization (see section 4.1.), as well as roll out of community-based services, such as those provided by CHAs, CHWs, nutrition volunteers and

[108] St. Josephs rural health center Lufwanyama District, April 2013.
[109] Serenje District HMIs, January to March 2013.
[110] Serenje District HMIS, January to March 2013.

CBDs. The requirement to use "official" data and the severe (75%) reduction in actual flow of funds[111] (compared to the "Yellow Book") to the districts as of May 2013, limits the overall impact of better planning on access and utilization of health services. When DHO teams were asked about their "revised plans" due to lack of money, they all responded "we have to prioritize our activities."

It is unclear if the districts will use the same processes with the same data sources and budget figures from the "Yellow Book" in the upcoming planning cycle, or if the experience from the current year will allow the districts to plan using more realistic estimates of the resources that are likely to be available in 2014 if current trends continue.

Although planned activities under the ZISSP Task Order included HMIS at the community level and support for drug supplies and logistics as two of the major HSS building blocks, the Evaluation Team found very little evidence that those activities are being implemented. ZISSP senior managers confirmed to the Evaluation Team that they "were not really focused on those activities." This was also confirmed by ZISSP's COR. Other donors, such as the European Union, are supporting the HMIS, while other USAID funded projects focus on commodity procurement, logistics and supply chain management[112].

CONCLUSION

The Evaluation Team found that in addition to supervision systems that ZISSP is addressing through mentorship, it was the same two elements, weak HMIS and commodities, as well as financing that were inhibiting effectiveness of some of ZISSP's HSS interventions.

RECOMMENDATION

Since addressing all of the issues that sometimes inhibit progress is not in ZISSP's mandate and largely out of its control, ZISSP should engage with its partners to collaborate and contribute according to their areas of expertise. However, overall solutions to the issues of supervision are not in ZISSP's mandate and require discussions at a level higher than the project.

Cross-Cutting Issue: Budget and Transparency

As of March 31, 2013, ZISSP has spent a cumulative total of $47,524,608.39 against the current obligations of $55,786,855.00. Cumulatively, ZISSP has spent 53.9% of the total estimated $88,092,613 ceiling[113], compared with 61% of the project time elapsed. A detailed analysis of ZISSP's budget was beyond the scope of the evaluation and the Evaluation Team did not perform a cost analysis of ZISSP's activities.

It is unclear why, as of the evaluation, some of ZISSP's activities were perceived in some provinces to already be rolling back due to a "lack of funds" and not necessarily as part of an exit strategy for the project. This was not the case in the national office. Overall, spend-down of project funds against planned activities seems to be fairly on target. Some PMOs said they thought ZISSP should model the transparency in financing - that is promoted by ZMLA - and in planning exercises, by sharing information about the costs of the activities they are supporting. They stated that this was essential for sustainability planning before the project ends. Community grantees and districts implementing IRS with ZISSP also reported slow release of funds but the Evaluation Team was not in a position to discover whether the delays were justified. An interview with ZISSP's financial department indicated that ZISSP's policies calling for certain disbursements to be retired before new disbursements were made might be one factor leading to some perceived delays. For community grants, ZISSP has hired additional staff to assist with the grants program. For IRS, the electronic payments using cell phones included network problems that delayed funds arriving into accounts in time to pay vendors. The Evaluation Team did not understand why ZISSP requires their community grantees to submit reports monthly when most development organizations are only required to submit reports quarterly.

[111] Figures provided by DMOs as of May 2013.
[112] USAID ZISSP COR, June 2013.
[113] ZISSP Quarterly Report Jan – March 2013.

Issues for Discussion at a Level Higher than the Project

Most discussions about district budget shortfalls and their procurement and supply challenges circled back to performance problems and uncertainty at the national level, which is beyond the control of the project and was not the focus of the evaluation. Challenges in HMIS data quality and differences of opinion about estimating catchment populations are long-standing system problems that cannot be improved with short-term technical assistance. Lack of capacity building and sustainability indicators at the beginning of programs, along with lack of baseline assessments, make giving full credit of the contributions to an HSS program very difficult. Overall failure to include coverage targets in donor supported public health programs will also make eventual impact assessments very problematic.

At times, effectiveness of capacity building and training of health workers, CHWs and CHAs in almost all of the interventions targeted by the project, has been hindered by periodic stockouts of several drugs such as Vitamin A, mebendazole, ACTs, rapid diagnostic tests and zinc to treat child diarrhea as part of IMCI. Many of these are in areas of the country not necessarily supported by many USAID partners. In some areas - EmONC and long term family planning - some trained health workers are still waiting for the drugs and equipment to implement what they have learned. ZISSP's SOW included plans for calculating CHW supply needs but it is unclear if they are still expected to do it and what purpose that activity was intended to serve. According to USAID/DELIVER, delivery of essential drug stocks available at the central level is reported to be well below estimated national needs[114] and some drugs, such as zinc for child diarrhea, were reported from district pharmacists[115] as not available at all. Most districts visited had received less than 30% of the funds they need to implement their annual plans at almost halfway through 2013, and that was the major reason cited by DHOs for the low stocks of drugs and supplies. At the time of the evaluation, stockouts of Nevirapine for PMTCT were also reported in several places[116].

Quantifying the extent of the challenges is difficult due to the weak national HMIS and other sources of information. However, all partners, managers and health workers agreed that, to some extent, some important drug supplies are approaching a very serious situation, while in some areas the problems are not as apparent.

The effectiveness of population, health and nutrition cascade training methodologies need to be re-examined in light of sustainability, country ownership, and HRH shortages. Relying on insufficient numbers of qualified senior health personnel to be away from their posts for training and follow-up supervision seems to work at cross-purposes with sustainable health systems support. The costs and benefits of this long-standing approach to health worker capacity building should be evaluated to inform future donor investment decisions.

The interest expressed by community development professionals in the MCDMCH to link with community level health programs, presents an opportunity for collaboration in USAID-supported community-based programs in multiple areas and should be explored.

[114] JSI Deliver, May 2013.
[115] Interviews with District Pharmacists, Serenje and Mkushi Districts
[116] Interview with ZISSP Southern Province Clinical Care Specialist and JSI Deliver, May 2013; interview with ZPCT2 provincial coordinator, Central Province.

ANNEXES

CONTENTS

TABLES

ANNEX I: EVALUATION STATEMENT OF WORK

SECTION C – DESCRIPTION / SPECIFICATIONS/STATEMENT OF WORK

PROJECT INFORMATION Identification Data

1. Project Title: Zambia Integrated Systems Strengthening Program (ZISSP)
2. Project Number: Contract No. GHH-I-00-07-00003
3. Project Dates: June 15, 2010 – December 13, 2014
4. Project Ceiling: $97,167,147 (with options)
5. Obligated Amount: $42,201,555
6. Implementing Organization: Abt Associates Inc.
7. Sub-contractors: Akros Research, the American College of Nurse Midwives, Banyan Global, BroadReach Institute for Training and Education (BRITE), Johns Hopkins University Center for Communication Programs, Liverpool School of Tropical Medicine, and the Planned Parenthood Association of Zambia.
8. Contracting Officer's Representative (COR): Dr. William Kanweka

II. BACKGROUND

Family planning services reach only a third of sexually active couples. Fertility has increased since 2002, from 5.9 to 6.2; rural fertility at 7.5 is among the world's highest (Zambia Demographic and Health Survey (ZDHS) 2007). Modern contraceptive use is 32.7%; with pills and injectables the most commonly used methods. Method mix has been static for the past eight years. There has been limited acceptance of longer term methods and consequently, overall unmet need is high at 26.5%.

The 2007 ZDHS shows Zambia's infant and under-five child mortality rates have both declined significantly since 2002, yet both are still high at 70 and 119 per 1,000 live births respectively. Newborn mortality is a major component of under-five mortality; currently it is at 34 per 1,000 live births, and increased from 23% in the 1990s to 29% in 2007. The maternal mortality ratio is 591 per 100,000 live births compared to 729 per 100,000 in 2001. More than 90% of Zambian women receive some antenatal care, yet only 47% of women deliver in health facilities and 46% have assistance of a skilled health provider. The 2007 ZDHS estimated that only 68% of children were fully immunized. High levels of stunting have not decreased since 1992; more than 45% of Zambian children under five are stunted and over 20% of these children are severely stunted. Exclusive breastfeeding of infants under six months increased from 40% in 2001 to 61% in 2007.

Zambia's HIV epidemic has stabilized at high prevalence: 14.3% among adults and 16.6% among pregnant women.[1] Adult HIV prevalence remains higher among women

(16.1%) than men (12.3%) and higher in urban areas (19.7%) than rural areas (10.3%). Although HIV incidence may have begun to stabilize, the absolute number of HIV positive individuals may increase as number of people on anti-retroviral drugs (ARVs) increases, there are fewer HIV related deaths, and the population continues growing.

Classified as a malaria high-burden country, Zambia reported 3.2 million new cases of malaria with 4,500 deaths due to malaria in 2009. Malaria accounts for 36% of hospitalizations and outpatient attendance nationwide.[2] A recent WHO impact assessment found that since 2001, deaths due to malaria have declined by 66%.

The Zambian health care system consists of a network of approximately 1,880 public and private health facilities, comprising health posts, rural health centers, urban health centers, and level one, two and three hospitals.[3] The Ministry of Health (MOH) supports the majority of facilities, though other sectors, particularly the faith-based sector, contribute to health services delivery. For many years, limited human resources have complicated Zambia's efforts to provide most health services. Despite donor support for training and retention schemes, the MOH is only able to employ approximately 50% of the clinicians required to staff health facilities.[4] The reality today is that rural health centers are often staffed by a single individual who has not had clinical training. Supervision has also been a challenge. The MOH is actively recruiting more personnel, yet it faces numerous constraints such as a high national wage bill, limited financial resources to fund new positions and poor infrastructure in rural areas that makes it difficult to retain health professionals.

The Government of Zambia (GRZ), through its Ministry of Health, is committed to addressing the above mentioned challenges and achieving the health-related Millennium Development Goals (MDG) by improving the quality of health care services, and providing greater and equitable health care access for its people. To support these objectives, USAID through the Zambia Integrated Systems Strengthening Program (ZISSP), is providing technical assistance to the MOH in order to strengthen the national health system. The aim is for GRZ to improve its capacity to effectively offer quality, high-impact services to the population at the national, provincial and district levels to reduce maternal mortality, under five mortality, the unmet need for family planning services and the incidence of malaria and HIV/AIDS.

[1] 2007 Zambia Demographic and Health Survey (DHS).
[2] Ministry of Health, National Malaria Control Action Plan for 2010.
[3] Ministry of Health, List of Health Facilities in Zambia, 2010.
[4] Ministry of Health, National Health Strategic Plan 2011-15.

III. PROJECT DESCRIPTION

The USAID-funded Zambia Integrated Systems Strengthening Program (ZISSP) is a four and a half year, $97 million contract tasked with supporting the Zambian

Ministry of Health (MOH) to strengthen skills and systems for planning, management and delivery of high-impact health services at the national, provincial and district levels. The primary objective of the project is to increase the utilization of high impact interventions in the interlinked areas of HIV/AIDS, Malaria, Family Planning (FP), Maternal Newborn and Child Health (MNCH) and Nutrition through a health systems strengthening approach. ZISSP applies a "whole systems" approach to strengthen the health system while enhancing use of quality, high-impact services. Additionally, ZISSP works with communities to promote increased use of public health services.

ZISSP operates at a national level, in all ten provinces and in communities in 27 target districts, which were selected in collaboration with the MOH. The beneficiaries of the project are MOH staff at the central, provincial and district level, community and faith- based organizations engaged in health-related activities and the general public that accesses services from the Zambian health system.

USAID/Zambia expects ZISSP to contribute to the achievement of Intermediate Result 3.2 (*IR 3.2: Health Status Improved*) of its Country Development and Cooperation Strategy (CDCS) 2011-15. This will be done through activities that strengthen health systems, and improve service delivery and community-level health behaviors. Additionally ZISSP is contributing towards implementation of the Mission's BEST Action Plan (Best Practices at Scale in Home, Community and Facilities (2011-2015)) and Global Health Initiative (GHI) Strategy.

In order to achieve the overarching project objective of increasing utilization of high impact public health interventions and fostering sustained improvements in management of the health system, ZISSP has adopted five strategies that will be used to implement project tasks. These strategies are:

1. Using a whole-system approach to unblock obstacles and strengthen the delivery and utilization of essential services.
2. Building Zambian capacity as the foundation for sustainability.
3. Increasing impact through partner engagement and integration.
4. Planning from the "bottom-up" to ensure relevance and participation.
5. Ensuring gender integration.

ZISSP has four core tasks and one optional task, all of which emphasize health systems strengthening, sustainability and integration:

Task 1: Strengthen the ability of the MOH at the national level to plan, manage, supervise and evaluate delivery of health services nationwide. In order to achieve this result, ZISSP will provide targeted technical assistance in human resources for health (HRH), family planning (FP), emergency obstetric and newborn care (EmONC) and

child health and nutrition (CHN). ZISSP has seconded technical experts in these four areas to the MOH headquarters. ZISSP has also seconded six technical experts (an entomologist, a geographic information systems specialist, an indoor residual spraying advisor, a logistics advisor, a case surveillance manager, and a monitoring and evaluation specialist) to the National Malaria Control Center (NMCC) to strengthen the ability of the Center to coordinate, oversee, and scale up nationwide indoor residual spraying and other malaria interventions.

Task2: Improve management and technical skills in order to increase use of quality health services within target districts. This will be accomplished through improved technical and managerial capacity of the provincial and district health teams. ZISSP has seconded three technical experts- a clinical care specialist (CCS), a management specialist (MS), and a community health coordinator (CHC) - to each of the nine Provincial Health Offices (PHOs). The CCS supports the province's technical supervision and mentoring of District Health Office (DHO) teams and facility-level clinicians. The MS works with the PHO to build provincial- and district-level skills for planning, budgeting, management, supervision, and reporting. The MS also facilitates the implementation of an innovative management and leadership training program through the BroadReach Institute for Training and Education (BRITE) which will strengthen the leadership and management capacity of PHO and DHO teams through short formal training sessions followed by application of new skills with close mentoring. The CHC is also based in the provincial office, but works primarily with district teams and communities to improve the interface between the health system and the community, thereby increasing utilization of health services.

Task 3: Improve community involvement in production of health in targeted areas. ZISSP will work to improve community engagement by ensuring support at the national level and improving provincial, district and facility coordination in health planning. The project will also leverage participation of community health workers and community health groups. CHCs work to improve the linkage between the community and the health system by assisting district-level staff to foster community participation in health planning and increase community ownership of health services. CHCs also work in the target districts to help community groups to advocate effectively for their health needs as active participants in the health planning process. Additionally, ZISSP supports communities and local organizations to develop and implement locally-led behavior change and communication (BCC) plans. Work at the community level will be implemented partly through a grants program for non-governmental organizations engaged in community-based health and BCC programs. ZISSP is working closely with USAID-funded Communications Support for Health (CSH) to implement comprehensives community based BCC programs.

Task 4: Ensure service delivery and other activities are effectively integrated at all appropriate levels in the health system through joint planning and in-kind activities with partners and appropriate private-public partnerships. ZISSP is working with the MOH to develop and apply resource mapping tools to capture information about – and to engage – the diverse group of local and international donors and implementing partners that support the Zambian health sector. Beginning at the central level, but with a primary focus on the district and community level, the project supports PHOs and DHOs to organize and appropriately integrate health resources, inputs and services through the planning process. For example, at central level, ZISSP assists the

MOH to integrate the work of donors and partners through technical working groups. At the district level, ZISSP helps the DHOs to integrate and capitalize on the contributions of community and faith-based organizations. The project also supports the development of public- private partnerships to expand the nation's capacity to deliver appropriate health services.

Optional Task 5: Support for the Global Hunger and Food Security/Feed the Future Initiative. The overall goal of this initiative is to sustainably reduce global poverty and hunger. At the request of USAID, the contractor will propose and conduct activities that support this overall goal and that are consistent with Feed the Future principles and task order parameters.

The ZISSP contract was awarded in June 2010. As of May 2012, $42,201,555 has been obligated into the award, across the five program areas (HIV/AIDS, malaria, FP, MNCH and nutrition). There have been two modifications to the contract to date, both of which added incremental funding to the award.

A shift in programming occurred in October 2011, when Zambia was chosen as a focus country for the Saving Mothers, Giving Life (SMGL) endeavor. Phase I of this endeavor is a one-year, interagency effort to reduce maternal mortality by 50% in four pilot districts (Kalomo, Lundazi, Nyimba, and Mansa) by September 2012. Mission Zambia did not receive any supplemental funding for these efforts, so USAID asked its existing implementing partners to adjust their activities so that they focus some of their existing activities on these four districts. ZISSP is supporting this effort by training health providers in EmONC as well as training and equipping Safe Motherhood Action Groups (SMAGs). ZISSP also employed four district SMGL Coordinators who coordinate the activities of the various implementing partners at the district level and act as the primary liaison with the DHOs.

IV. PURPOSE AND USE OF EVALUATION

The USAID/Zambia Health Office seeks an independent team to perform a mid-term performance evaluation of the ZISSP program.

The objectives of this midterm evaluation are three-fold:

Part A (Retrospective): To evaluate the progress made toward achieving project objectives, including an assessment of project design (conceptual framework) in light of implementation experience to date.

Part B (Prospective): Based on the above findings, to make recommendations for ZISSP project implementation through 2014, including the optimal mix of activities and funding for achieving project objectives and sustainability taking into account the current Zambian Government structure that involves two ministries dealing with health, the current Zambian health policies, the current U.S. government policies and the current relations with different partners and donors.

Part C: Using the above findings, frame issues to debate/discuss/resolve at a level higher than the project, e.g. at the level of the GRZ and/or other donor organizations.

USAID Zambia will disseminate the report widely with relevant stakeholders and project beneficiaries. The findings will also be used in project modifications such as technical approaches based on the recommendations.

The evaluation will provide USAID/Zambia, Ministry of Health, Ministry of Community Development, Mother and Child Health, and the implementing partner with objective information on what has been achieved to date, what is working and why, as well as what may not be working and why. This information will inform decisions to make appropriate modifications and mid-course corrections, if necessary, in order to assure achievement of life of project targets.

V. EVALUATION QUESTIONS

The Contractor shall answer the following evaluation questions:

1. Progress towards results

What progress has been made towards improving access to and utilization of family planning, HIV/AIDS, malaria, MNCH and nutrition information and services in ZISSP target districts?

2. Capacity Building

What progress has been made to strengthen the capacity of Ministry of Health (MOH) and National Malaria Control Center (NMCC) staff at each level (national, provincial, and district) to plan, design, implement, manage, monitor and evaluate health programs within each of the five program areas (1) HIV/AIDS, (2) malaria, (3) family planning, (4) maternal, newborn and child health (MNCH) and (5) nutrition)?

In what ways has community participation in health planning, implementation, monitoring and improving health practices in ZISSP target districts been strengthened?

3. Human Resources for Health

In what ways has the MOH's capacity to attract and retain health workers in rural positions improved?

What are the perceptions of health workers who are currently on the Zambia Health Worker Retention Scheme about how effectively it is managed?

4. Coordination and Integration

In what ways has coordination and synergy of HIV/AIDS, MNCH, Nutrition, FP, and Malaria services provided by stakeholders (MOH, USG, other donors, private sector health facilities, etc.) in ZISSP target districts been strengthened?

5. Country Ownership

What is the perception of MOH and NMCC regarding ZISSP seconded staff's role in building capacity of Government of the Republic of Zambia (GRZ) counterparts to plan, design, implement, manage, monitor and evaluate health programs at the national, provincial and district levels?

6. Gender Integration

To what extent have women been empowered to take action in support of health behaviors and interventions in ZISSP target districts?

VI. EVALUATION DESIGN AND METHODOLOGY

Sources of Information

The Contractor shall review background material, including but not limited to the following documents:

Section C (Statement of Work) of the ZISSP Task Order
ZISSP PMEP (currently being revised)
ZISSP Environmental Management and Mitigation Plan
ZISSP annual work plans
ZISSP quarterly and annual reports, portfolio review documents
Zambia Demographic and Health Surveys
National Food and Nutrition Strategy 2011-15
National Health Strategic Plans (2006-10 and 2011-15)
Human Resources for Health Strategic Plans (2006-10 and 2011-15)
USAID/Zambia's Global Health Initiative Strategy
USAID/Zambia's Integrated Nutrition Framework
Relevant narratives from the Malaria Operational Plan (MOP FY 2010, FY 2011, FY 2012)

These documents will be provided electronically (via email) by the Mission by the first day of the period of performance. Other sources of information include:

Health Management Information System (HMIS) reports
Performance Assessment/Technical Support Supervision reports
MOH and NMCC TWG meeting minutes
District Health Action Plans and reports.

While in country the Contractor shall meet with MOH and Ministry of Community Development, Mother and Child Health staff at all levels, USAID and other USG technical staff, technical staff from other USG-funded projects, other cooperating partners (Donors) implementing health programs, community- and faith-based organizations implementing health programs, and community members and clients at GRZ health facilities in ZISSP target districts. Other USG-funded projects shall include Communications Support for Health (CSH), Partnership for Integrated Social Marketing (PRISM), and Zambia Prevention Care and Treatment Partnership II (ZPCT II). Cooperating partners shall include the United Kingdom's Department for International Development (DFID), Canadian International Development Agency (CIDA), Swedish International Development Cooperation Agency (SIDA), UNICEF, and WHO.

Methodology

The Contractor shall apply both qualitative and quantitative methods and approaches for collecting and analyzing the information required to address the evaluation questions. The Contractor shall submit a proposed methodology for undertaking this evaluation prior to implementation.

The methodology must include, but not be limited to the following;

Document and data review: The Contractor shall conduct a document and data review of all the sources cited in the "Sources of Information" section above.

Key Informant Interviews: The Contractor shall conduct qualitative, in-depth interviews with key stakeholders and partners. The Contractor shall conduct face-to-face interviews with informants. When it is not possible to meet with stakeholders in person, telephone interviews shall be conducted.

Interviews: The Contractor shall conduct one-on-one interviews with a sample of GRZ employees and community members who have attended a ZISSP sponsored training in order to assess the quality of skills, knowledge transfer and the sustainability of the program.

Mini-surveys: The Contractor shall use a mini-survey to collect information from the nine Provincial Medical Officers, 27 District Medical Officers and 35 staff seconded by ZISSP to the MOH and NMCC.

Direct Observation: The Contractor shall directly observe capacity development activities conducted by ZISSP. The Contractor shall visit at least three of the nine Provincial Health Offices and nine of the 27 target districts.

Participatory Process: The Contractor shall conduct the assessment in a participatory manner. The Contractor shall consult with the Ministry of Health, the National Malaria Control Center (NMCC), the Ministry of Community Development, Mother and Child Health, and the implementing partner in an attempt to identify needs or gaps. To ensure ownership of the results and recommendations, the Contractor shall present their draft findings to the implementing partner for review and comments prior to finalizing the report.

Consultation with USAID: The contractor shall consult regularly with the USAID Contracting Officer's Representative (COR), who is responsible for managing the evaluation of Zambia Integrated Systems Strengthening Program.

In-house review: The first draft report will be peer reviewed by a team comprising USAID and other USG staff members. USAID will provide feedback from this review to the Contractor within five business days.

Consultation with beneficiaries and stakeholders: The Contractor shall visit and verify program activities in the field and consult widely with beneficiaries and other stakeholders. The input from the beneficiaries and stakeholders shall be used to inform recommendations and future plans for the program.

VII. EVALUATION DELIVERABLES, TASKS AND TIMELINES

The contractor shall deliver the following:

1. Final Methodology: The proposed methodology shall be submitted to the COR for concurrence within ten days after the contract start date.
2. Work plan: A detailed work plan, including plans for consultation with USAID and its partners, five days following the start of the contract.
3. The final schedule, interview and site visit protocols and a draft evaluation report outline shall be submitted to the COR for review and feedback on Day 5 of the Evaluation Team Planning Meeting.
4. Briefings: The Contractor shall organize and provide entry and final briefings for USAID/Zambia staff, other USG agencies and staff, implementing partners and host government officials. USG, implementing partner and GRZ briefings will be held separately and the content of the meetings shall vary as appropriate.
5. Interview notes and resource documents: The Contractor shall provide summaries of all key meetings, workshops and discussions conducted in the course of the ZISSP mid-term evaluation. These summaries shall be submitted to the COR along with copies of any relevant documents and reports gathered in the course of the evaluation.
6. Draft mid-term evaluation reports (2): The Contractor shall submit two hard copies and one electronic copy of the *first* draft report to the COR six working days prior to the final de-briefing. In the report, the Contractor shall separate the findings, conclusions, and recommendations for each question. All recommendations included in the report shall be practical, specific, and action-oriented and designate the proposed implementer and timeframe. The Contractor shall submit a *second* draft report (two hard copies and one electronic copy) to the COR before the evaluation team leader's departure from Zambia.
7. Final evaluation report: The final evaluation report must incorporate changes requested by USAID and the GRZ, as agreed by the Contractor, USAID and GRZ. The Contractor is not obligated to modify the report to incorporate changes that will alter the findings. When applicable, evaluation reports must include statements regarding any significant unresolved differences of opinion on the part of the funders, implementers and/or members of the evaluation team. The Contractor shall submit three hard copies and one electronic copy of the final report to the COR within ten days after receiving input on the second draft report from USAID and GRZ. The evaluation report must be written in English and formatted for size A4 paper.

Evaluation Report Format

The Contractor shall prepare the draft and final evaluation reports in accordance with the following:

Executive Summary (6 pages maximum length): Brief description of ZISSP Project key results/impacts, and evaluation's major findings/recommendations and lessons learned.

Main body (40 pages maximum length):

Description of the project: Drawing from the ZISSP Project, concisely describe the rationale of ZISSP's Health System Strengthening interventions, what constraints/opportunities they were meant to address, and what, specifically, the program has been trying to accomplish. Specify the problem(s) the program is facing and propose ways to overcome these challenges.

Evaluation purpose, methodology: Describe, briefly, types and sources of evidence and methodologies employed to complete the evaluation SOW.

Findings: Present findings, with supporting evidence, with regard to questions/issues in the SOW and other pertinent matters that should arise during the course of the evaluation.

Recommendations: Present and synthesize pertinent recommendations as they relate to ongoing planning, management and implementation of the ZISSP Program. Also address matters of long-term sustainability and impact.

Annexes:
The evaluation report shall also contain the following:

1. Final evaluation schedule
2. Interview and site visit protocols and questionnaires
3. List of resource documents reviewed
4. List of organizations and persons contacted
5. Summary reports from group meetings and workshops

The mid-term evaluation will take place over approximately 12-weeks with in-country tasks commencing 18 days after the first day of the period of performance. Six-day work week is authorized for the Zambia-based portion of the evaluation. Premium pay is not authorized.

Total level of effort (LOE)—96 days of LOE for Evaluation Team Leader (including four international travel days); 87 days for Program Evaluation Specialist (including four international travel days); up to 75 days each for three local Program Experts; 62 days for Evaluation Logistics Coordinator.

Logistics support: The contractor shall be responsible for all logistics support required by the evaluation team, including office and meeting space and equipment, secretarial support, photocopying, international and local communications, international and local travel and transport, and preparation of the final evaluation report. The Contractor, in collaboration with the USAID/Zambia COR and Abt Associates, Inc., shall organize meeting space and materials, initial partner meetings, and site visit schedule and related logistics in advance of the in-country portion of the evaluation. The contractor shall organize and manage travel and per diem for all international and local consultants and GRZ officials (if any) participating in the mid-term evaluation.

VIII. TEAM COMPOSITION

The Contractor shall provide two senior consultants, one local logistics assistant, and three local (Zambia-based) consultants:

A senior team leader experienced in evaluating large health and/or institutional capacity building programs. A senior team member with expertise in evaluation design, specifically large Health System Strengthening programs with multiple components.
Three (3) local expert consultants with combined expertise covering all the following technical areas: HIV/AIDS, MCH, Nutrition, FP/RH and Malaria, and public-private partnerships. A local evaluation logistics coordinator.

In addition, one or more USAID/Zambia staff will serve as resource persons to the evaluation team and in this role, the USG staff will be restricted to providing technical guidance pertaining to questions the evaluation team might have during the implementation of the SOW. The USG staff will not participate in the actual assessment and data collection process of this evaluation. Two program officials from the Government of Zambia (Ministry of Health and Ministry of Community Development, Mother and Child Health) will be invited to participate as team members during the planning and field portion of the evaluation, but will have no formal responsibilities related to preparation of the final report (site visit related travel and per diem costs for these officials must be budgeted under this contract and managed by the contractor). The contractor shall observe current USG policies with regard to allowances payable to Government of Zambia staff members.

Senior Evaluation Team Leader: The team leader must have extensive program implementation and evaluation experience; with particular focus on Health and/or Institutional Capacity Building programs. S/he will agree to fulfill his/her responsibilities in the negotiated time-frame, spending nine weeks in country, and will play the lead role in guiding the evaluation process.

The Senior Evaluation Team Leader must meet the following requirements:

Education: An advanced degree (MD, RN, MPH, PhD, MA, MS, or equivalent) from an accredited institution in medicine, public health, or any of the social sciences pertinent to work with system strengthening in health.

Work Experience: Minimum 10 years of progressively responsible experience in the design, implementation, and evaluation of health programs with demonstrated technical expertise and skills in health system strengthening and/or institutional capacity building in resource limited settings.

Skills and Abilities: Demonstration of strong analytical, managerial, and writing skills is critical for this evaluation assignment. The team leader should have demonstrated strong leadership, analytical, management and organizational, communication and interpersonal skills. In addition, the Team Leader must be able to interact effectively with a broad range of internal and external partners, including international organizations, host country government officials, and NGO counterparts. The Team Leader must be fluent in English and have proven abilities to communicate clearly, concisely, and effectively, both orally and in writing. The senior team leader must be

able to produce a succinct, quality document that assesses implementation successes and shortfalls and lays out actionable recommendations to guide and improve the ZISSP project during its final years of implementation.

Program Evaluation Specialist: This team member must have extensive knowledge of and experience with the monitoring and evaluation of large health and/or institutional capacity building programs. Knowledge of one or more of the relevant health technical areas (MCH, Nutrition, FP/RH, Malaria and HIV/AIDS) is essential.

The Program Evaluation Specialist must meet the following requirements

Education: MD, RN, MPH, PhD, MA, MS, or equivalent from an accredited institution in medicine, public health, or any of the social sciences pertinent to working in health programs.

Work Experience: Minimum 6 years of progressively responsible experience in the design, implementation, and evaluation of health programs, with demonstrated technical expertise and skills in health system strengthening and/or institutional capacity building in resource limited settings.

Skills and Abilities: The Program Evaluation Specialist must have strong, demonstrated analytical, managerial, and writing skills. The Specialist must be able to interact effectively with a broad range of internal and external partners, including international organizations, host country government officials, and NGO counterparts. The specialist must be fluent in English and have proven abilities to communicate clearly, concisely, and effectively, both orally and in writing.

Program Experts (Local Consultants): Three (3) consultants with combined expertise covering all the program areas supported under ZISSP (Human Resources for Health, HIV/AIDS, MNCH, Nutrition, FP/RH and Malaria). The Program Experts will be local consultants, fluent in English, with extensive knowledge of and experience with integrated health programs and preferably, health system strengthening in Zambia. The Contractor is responsible for identifying expert consultants with the skills mix required to assess the full range of technical and managerial program priorities under ZISSP.

Program Experts must meet the following requirements:

Education: MD, RN, MPH, Ph.D., MA, MS, or equivalent from an accredited institution in medicine, public health, or any of the social sciences pertinent to working in health programs, with special emphasis on one or more of the following: Human Resources for Health, HIV/AIDS, MCH, Nutrition, FP/RH and Malaria. The Program Experts selected will, together, possess the range of technical competencies and expertise required to fully assess ZISSP implementation progress and issues.

Work Experience: Minimum 6 years of progressively responsible, Zambia-based experience in the design, implementation, and/or evaluation of health programs.
Skills and Abilities: The Program Experts must have strong, demonstrated analytical and writing skills. The Program Experts must be able to interact effectively with a broad range of internal and external partners, including international organizations, host country government officials, and NGO counterparts. The Program Experts

must be fluent in English and have proven abilities to communicate clearly, concisely, and effectively, both orally and in writing.

Evaluation Logistics Coordinator: This team member will be a local consultant with a demonstrated ability to be resourceful and execute complex logistical coordination successfully.

The logistics coordinator must have a combination of education and work experience that lends itself to the following skills and abilities:

Perform tasks independently with minimal supervision; Manage time effectively; Able to interact effectively with a broad range of internal and external partners, including international organizations, host country government officials, and NGO counterparts;
Must be fluent in English, and have proven abilities to communicate clearly, concisely, and effectively, both orally and in writing.

ANNEX II: EVALUATION METHODS AND LIMITATIONS

Evaluation Methodology

The MTE team used a mixture of quantitative and qualitative methods including: field visits to national GRZ offices, 5 out of the 9 original PHO and DHO, HF, pre-service training institutions, and interviews communities in 12 of ZISSP's focus districts, including two that are included in the SMGL initiative. Two MCD/MCH representatives, one from the national level and one from the provincial level, accompanied the team and provided inputs on the findings.

Document Review

Review of key documents related to project activities including GRZ documents, USAID documents, USAID Task Order, project documents including Annual Reports, Work Plans, PMP reports, project studies, guidelines, and training materials, health, population and nutrition policy and strategy documents, and peer-reviewed technical literature, research reports and project documents and reports from other USAID and development partner projects. A list of documents reviewed for the evaluation is included in the references in Annex VII. ZISSP senior managers also briefed the MTE team with overviews on most of their activities.

Quantitative Methods

Best available quantitative information was reviewed including GRZ HMIS reports and HMIS databases, HF registers, as well as SMGL, IYCF, CBD, and CHW registers and reporting forms. Results from the 2007 Demographic and Health Survey (DHS), the 2010 Malaria Indicator Survey (MIS) and preliminary 2012 MIS data were reviewed. HF checklists were used to assess availability of health personnel, use of job standard operating procedures and updated guidelines; array of health services provided, and availability of drugs, equipment and supplies. District level drug and supply request orders were compared with delivery documents in selected districts.

In addition to review of existing quantitative data, the evaluation team conducted two original quantitative surveys. One was a Likert-scale assessment of opinions about the current attainment of the ZISSP objectives and effort to be made in the remaining part of the program to completely attain objectives. The Likert Scale Survey was administered to DMO, PMO, HW on the Zambia Health Worker Retention Scheme (ZHWRS), ZISSP personnel seconded to MoH provincial health offices (PHO), national headquarters and the NMCC. The second survey assessed CHAs' experience with supervision since assuming their duties after completing their initial training.

Qualitative Methods

Briefings and follow-up interviews were conducted with ZISSP and project partner senior managers. KIIs were conducted with MOH, NMCC and MCD/MCH managers at the national, provincial and district level as well as representatives of other USAID health projects and health development partners. Individual and group interviews were conducted with selected HW, community health, FP and nutrition volunteers, NHC and clients. For FGD, verbal informed consent forms were translated and signed by an observer before clients were interviewed. No personally-identifiable

client data was collected. Group and individual interviews were conducted with USAID health office managers, ZISSP managers and seconded national level personnel, MOH and MCD/MCH representatives. Group interviews were conducted with ZISSP provincial seconded staff, PHO and DHO staff.

Limitations

HSS programs are known to be difficult to evaluate; even when contributions are very strong, attribution is often very difficult. WHO's HSS "building blocks" are intended to be inter-dependent, with contributions coming from many partners. When things work well, it is hard to give credit to one partner; when they do not, one partner may or may not be the reason. Many developing countries face challenges in developing data of sufficient quality to permit tracking of scale-up of health interventions of strengthening health systems. Due to the quality and availability of data, and based on the WHO Operational Framework for Monitoring and Evaluating Health Systems Strengthening, [117] the MTE could only address project inputs and processes, and to a lesser extent outputs.

Responsibility for some important GRZ health system functions was in the process of shifting from the MOH to MCD/MCH and current location of some offices and personnel could not be determined. Some MCD/MCH managers were not available for interviews during the evaluation due to schedule and travel conflicts or illness and some development partners were also out of the country and not available for interview.

The most recent aggregated data at the provincial level is from 2011 and, aside from MIS, population-based health data has to rely on the 2007 DHS. There are differences in the population size estimates from the national statistical office and those compiled by head counts of the communities by the NHC for their HF catchment areas and within the districts. Some DHO expressed the view that they should use the head counts as denominators of indicators that require total populations for planning and budget allocations, but they are required to use only the populations from the national statistical office. These differences, real or imagined, could affect the value of coverage estimates related to high-impact health interventions[118].

A detailed description of the evaluation methods used to address each evaluation question can be found in the following Evaluation Matrix:

[117] World Health Organization, Monitoring and Evaluation of Health Systems Strengthening: An Operational Framework, 2010, Geneva.
[118] DHO, Kapiri District, May 2013.

EVALUATION QUESTION	DATA COLLECTION TOOLS	WHO TO INTERVIEW
1. Progress Towards Results What progress has been made towards improving access to and utilization of family planning, HIV/AIDS, malaria, MNCH and nutrition information and services in ZISSP target districts?	Key Informant Questions for Ministry Of Health, Ministry of Community Development/MCH and National Malaria Control Center	MOH: PS, Directorates of HRA, Policy and Planning, Technical Support Services, Clinical Care and Diagnostics, Services, Public Health and Research MCD/MCH: PS, Director MCH, , Director, Safe
	Key Informant Interview tool for Provincial and District levels, including seconded ZISSP staff – comprehensive questions	PMO and DMO, provincial and district planners, DHIOS, management specialists, IEC health promotion specialists, clinical mentoring teams, clinical care specialists,
	Mini Survey for PMO, DMO	PMO and DMO, ZISSP
	Key Informant Interview with ZISPP partners	AKROS, BRITE, PPAZ, London School Of Hygiene and Tropical
	Key Informant Interview tool with other collaborating partners and stakeholders	CDC for malaria and Safe Motherhood; EGPAF for HIV/AIDS and management training , CIDRZ, SMGL partners, NIPA, UNICEF, UNFPA, DFID malaria and EmONC; World Bank (malaria); WHO, SIDA, MACEPA, ZPCT2, JSI, MCHIP (and USAID CORs), for overall perspective. (For other questions see below). at district and community level where possible
	One on One Interview tool for Health Workers involved in ZISSP supported Capacity Building (different cadres of health care providers) Health Facility Service Delivery Capacity Check List	Health Facility Managers HW in RHC and Health Posts SMAG. IMCI, FANC, IYCF Trainers and Supervisors CHA Supervisors District and Provincial MNCH Coordinators Provincial and District Clinical Care Specialists District and Provincial Nutrition Focal Persons

EVALUATION QUESTION	DATA COLLECTION TOOLS	WHO TO INTERVIEW
		District Malaria Focal Persons District Public Health Officers Provincial and District Information Officers Provincial and District Health Promotion Officers Provincial and District HR Officers Provincial and District EHT District Pharmacists Provincial and District Planners Midwifery Pre-service Tutors Referral Hospital EmONC and IMCI focal persons ZISSP Clinical Care Specialists, Management Specialists, and Community Health Coordinators
	Community Health Assistants interview tool Focus Group Discussion tools for: Safe Motherhood Action Groups tool Neighborhood Health Committees and Health Center Advisory Committees Tool Community health volunteers including community heatlh workers, Infant and Young Child Feeding volunteers, CBDs, drama groups Beneficiaries of Services	SMAG volunteers, Community Health Assistants, Community Health Workers, NHC members, HCAC members, Community Based Distributors, IYCF volunteers, , CBDs, drama group members, beneficiaries of services (pregnant women and new mothers)

EVALUATION QUESTION	DATA COLLECTION TOOLS	WHO TO INTERVIEW
2. Capacity Building 2.1. What progress has been made to strengthen the capacity of Ministry of Health (MOH) and National Malaria Control Center (NMCC) staff at each level (national, provincial, and district) to plan, design, implement, manage, monitor and evaluate health programs within each of the five program areas (1) HIV/AIDS, (2) malaria, (3) family planning, (4) maternal, newborn and child health (MNCH) and (5) nutrition)?	All interview tools noted above plus: Service delivery records Training records Trainee interviews Community Health Assistant Survey Likert Survey	Same as for Question 1.
2.2. In what ways has community participation in health planning, implementation, monitoring and improving health practices in ZISSP target districts been strengthened?	Interview tool for Community Health Assistants Focus Group Discussion tools for: Safe Motherhood Action Groups Neighborhood Health Committees Health Center Advisory Committees Key informant Interview with provincial and district staff Interview tool for grantees	SMAGs and other Community volunteers, NHC members, NHC/HCAC members ZISSP seconded community health coordinators Grantee organizations where possible
3. Human Resources for Health 3.1. In what ways has the MOH's capacity to attract and retain health workers in rural positions improved?	Interview questions for MOH, MCD/MCH and NMCC Health facility service delivery capacity checklist Key Informant Interview with PMO and DMO Key Informant Interviews with RHC managers Key Informant Interviews with HW on the ZHWRS Mini Survey for PMO, DMO	MOH HRA Directorate; ZISSP seconded staff PMOs and DMOs Health facility managers Health workers on the ZHWRS DMOs in districts where ZHWRS-supported HW are posted HF managers where ZHWRS-supported HW are posted

EVALUATION QUESTION	DATA COLLECTION TOOLS	WHO TO INTERVIEW
		District HR records
3.2. What are the perceptions of health workers who are currently on the Zambia Health Worker Retention Scheme about how effectively it is managed?	Key informant Interviews for health workers on the health workers retention scheme Key informant interviews with Provincial and District HR Officers and PMO/DMO	Health workers supported by retention scheme, if possible supported by ZISSP HR Officers PMO/DMO
4. Coordination and Integration In what ways has coordination and synergy of HIV/AIDS, MNCH, Nutrition, FP, and Malaria services provided by stakeholders (MOH, USG, other donors, private sector health facilities, etc.) in ZISSP target districts been strengthened?	Key Informant Interview tool with other collaborating partners and stakeholders Interview questions for MOH, MCD/MCH and NMCC Key Informant Interview with Provincial and District Staff Mini Survey for PMO, DMO Key Informant Interviews with Development Partners	CDC and Implementing partners eg, EGPAF, ZPTCII, CIDRZ, Community Grant Recipients, SMGL partners at district and community level where possible MOH Directorates of HRA, Policy and Planning, Technical Support Services, Clinical Care and Diagnostics, Public Health and Research MCD/MCH: PS, Director MCH NMCC: , Director, ZISSP seconded staff, PMOs and DMOs District and Provincial level development partners
5. Country Ownership What is the perception of MOH and NMCC regarding ZISSP seconded staff's role in building capacity of Government of the Republic of Zambia (GRZ) counterparts to plan, design,	Interview questions for MOH, MCD/MCH and NMCC Key Informant Interview with PMO and DMO Mini Survey for PMO, DMO Country Ownership measurements from GHI document	MOH Directorates of HRA, Policy and Planning, Technical Support Services, Clinical Care and Diagnostics, Public Health and Research MCD/MCH: PS, Director MCH NMCC: , Director, ZISSP seconded staff PMOs and DMOs DHO Management Teams

EVALUATION QUESTION	DATA COLLECTION TOOLS	WHO TO INTERVIEW
implement, manage, monitor and evaluate health programs at the national, provincial and district levels?		
6. Gender Integration To what extent have women been empowered to take action in support of health behaviors and interventions in ZISSP target districts?	Interview questions for MOH, MCD/MCH and NMCC Key Informant Interview with Provincial and District Staff and ZISSP staff Focus group tools for NHCs and HCACs; SMAGs, CHWs, IYCF volunteers Mini Survey for PMO, DMO Focus Group Discussions with groups of HF clients ZISSP training records	MOH Directorates of HRA, Policy and Planning, Technical Support Services, Clinical Care and Diagnostics, Public Health and Research MCD/MCH: PS, Director MCH NMCC: , Director, ZISSP seconded staff PMOs and DMOs NHC and HCAC members SMAG members HW interviews Client interviews ZISSP Capacity Building Staff ZISSP Gender Strategy focal persons

ANNEX III: DATA COLLECTION INSTRUMENTS

FGD Tool for HCACs (and NHCs)

Date, District, Group, Number of Males, Number of Females, Age range of participants.

Get verbal consent from all members, have an observer sign acknowledgement of verbal consent.

Standardize Introduction.

When was your HCAC (or NHC) established? *Has it been continuously operating?*

How long have you been members of the HCAC or NHC? *Record the time range.*

How many women, and how many men are on your committee? *Has there been a change in gender ratio since the beginning of 2012?*

What motivated you to become a HCAC or NHC member? *Did you volunteer or were you selected? If selected, by whom?*

How often does the HCAC or NHC meet? Where? Who calls the meetings? What support if any do you receive for attending meetings (eg, transport stipend)?

What training have you received? *On what topics (listen for planning, MNCH, IYCF, Safe Motherhood, malaria, FP, nutrition, HIV). From whom, when, where? Have you learned about care of newborn babies?*

What do you do as a HCAC or NHC member? *Are you involved in the annual planning process? If so, how? Are there any barriers and challenges to your participations?*

Do you play any role in advising or giving feedback on quality of health services at HF? *If so, please describe. Do you see any changes resulting from your input or feedback? If so, please give an example. After you submit annual plans, do you see evidence of progress in implementation of your plans?*

Who, if anyone, provides mentoring support or skills building support to the HCAC or NHC? *Has this been helpful? Why or why not?*

Is there a relationship between your HCAC or NHC and:

CHAs?

CHWs?

SMAG members?

BCC groups (RLS, drama, other)?

What in your view are the main contributions of the HCAC or NHC?

In your view, are there other activities that the HCAC or NHC could undertake to promote the health of communities in this province/district? If so, please describe.

Focus Group Discussion Tool for Safe Motherhood Action Groups

(In notes, include Date, District, Enumerators, number of women, number of men, , age range. Identify whether group is in a SMGL district.)

Standard Introduction. Ensure that acknowledgement of observation of verbal consent is signed.

When was your SMAG formed? How many women and how many men are in your group?

What activities does your SMAG do? *Do all members do the same activities? How many men and how many women are in your group? Does your SMAG group: provide education on caring for newborn babies? Promote care for mothers in the days and months after they deliver their babies? Conduct PNC visits? Encourage mothers to go to HC for PNC?*

Do you keep a record of what you do and when you do it? *If yes, where are these records kept? Do you send any reports to the health center? If yes, how often? Who receives these reports? What kind of information is in these reports?*

What is the size of your catchment area in kilometers? *What transportation means do you use to reach the women? How do women get to the health facility?*

Do you receive any support for your SMAG activities? *From where? Does someone supervise your work? From whom/when/where? What happens during supervision? Is this support sufficient? Why or why not?*

What training have you received since July 2010? *From whom, when, for how long? On what topics? In your view, is this training sufficient for your work? If no, what additional training do you need?**

Does your SMAG interact with the health post or health center nearest your community? *If so, how? Do you make any referrals to health centers as part of your volunteer work? If so, please give examples. If you make a referral, is there any record that you made the referral?*

Have you seen any changes in safe motherhood, including gender roles related to safe motherhood? *If so, please give examples. If so, what do you think has influenced these changes?*

Since your group became active, have more mothers gone to the health facility to deliver their babies?

Since your group became active, have more women gone for ANC or, if they were already going for ANC, are they going for more visits or at a different time during their pregnancy?

Have you seen any other changes in safe motherhood, including gender roles related to safe motherhood? *If so, please give examples. If so, what do you think has influenced these changes?*

What do you see as the barriers to increasing the number of pregnant women who go for ANC to increasing the number of women who deliver their babies at health facilities?

What do you think are key gender issues related to safe-motherhood in this community? *How does your group address these issues? Does your work empower women for safe motherhood? Please give examples. Does you work empower men for safe motherhood? Please give examples. Have you faced any challenges with regard to male SMAG members providing education and referral services at community level?*

Do you think that your SMAG would continue if funding and other (resources, materials) support from international partners were to end? Why or why not?

Focus Group Discussion Tool for Service Beneficiaries

Include information on Health Facility Name, Province, District and Respondent Gender

Access and Availability of Health Services

Where do people in this community usually prefer to go when they have any health problem? Why is it so?

What could be the approximate distance between your village and this health facility?

What are the services offered at this health facility?

Would you say that more people have been utilizing services at this health facility in the past 2 years? If yes, what are the reasons for this increase in accessing services?

When you visited the health facility, was any one available to attend to you immediately? If not what were the reasons?

Are there health education and behavior change activities happening at community level? If yes. Who provides these services?

In your own opinion, do you think that the community based health information and services have contributed to the increase in the number of individuals if any, utilizing health services at the health facility?

What additional services would you like to receive at this health center?

What changes, if at all any, would you like to have/suggest to improve service delivery at this facility?

Overall satisfaction

Were you satisfied with the service/s you received today or any other day that you visited this health facility?

What do people in this community state as things that please them when they visit this health facility?

Interview Tool for ZISSP Grantee Organizations

What activities are you implementing with ZISSP grant funding support?

What capacity building support have you received from ZISSP toward effective grant reporting?

How many staff are involved in the management of grant funds?

What additional CB support do you need, if any, to meet reporting requirements?

Are grant tranches being received in a timely manner? If not, what are the reasons for this from your view? What are the effects on your activities, if any? What suggestions do you have to resolve this challenge, if any?

How do you hope to sustain project activities after grant ends?

Is this grant helping you to build the internal capacity of your organization? If so, how?

Is this grant helping you to build capacity of community volunteers? If so, how?

Do you provide any supportive supervision as part of your grant activities? Or as part of other project activities? If so, please describe.

Is your organization qualified to provide broader supervision to community volunteers? If so, please explain.

How are you measuring the results of your grant supported activities?

In your opinion, has the grant made a difference at community level to date? How do you know?

Based on your grant experience to date, do you have any recommendations for ZISSP's second round of grant application and funding?

Key informant Interview with Provincial and District Staff - Comprehensive

INSTRUCTIONS

Thank you for taking time to participate in the ZISSP program evaluation interview. My name is_____ and I will be asking you some questions which will guide the interview process. The information provided will be handled with confidentiality.

The questionnaire comprises three sections; background, capacity building and human resources for health. Both open and closed ended questions are included in the questionnaire. The closed ended questions have instructions for ticking the appropriate option, and providing descriptive information when requested to list and specify. You are required to provide descriptive information for all open ended questions

Section One: Background information

Date:_____ **District:**_____
Title of Respondent _____ **Sex:** Male____ Female_____
Program Area (if applicable):_____
Enumerators name:_____

Section one: Progress towards results	
1.	In your view, has there been any progress in ZISPP supported districts in the following areas:
	Training: ----------
	Developing training manuals/resources: ----------
	Developing policies, strategies and guidelines: ----------
	Conducting Research and assessments: ----------

	Systems development and sound strategic approaches: --- --- --- --- --- ---
	Community mobilization for maternal and neonatal outcomes. --- --- --- --- --- ---
	Other, specify: --- --- --- --- --- ---
2	In your view, have ZISSP activities affected any changes in the following areas: *Coordination of key stakeholders; ongoing clinical mentoring, Supportive supervision, Providing human resources through seconded expert staff and support of retention scheme, Providing financial resources, Participation and provision of TA support in national, provincial and district MOH planning and budgeting activities, Implementation of grants program/capacity building of grantees in grants management and organizational development*
Section two: Capacity Building	
3	What ZISSP strategies or activities are you aware of that have helped to strengthen community participation in improving health? **[Prompt for SMAGs, NHCs, HCAC]**
4.	Based on your experiences or observations, how have ZISSP community focused activities addressed gender issues (e.g. household decision making, gender imbalances among health workers or volunteers), if at all?
5	Based on your experience or observations, do you believe that quality of care at community level has improved? If so, what groups of community members have benefited most from ZISSP activities? Are there still groups that are yet to be reached?
Section three: *Human Resources for Health:*	
6.	In what ways has ZISSP helped to attract and retain health workers in rural positions?
7	In your opinion this context do you have an opinion about any benefits of the following specific

	capacity-building programs promoted by ZISSP:
8	What are the most important issues related to attracting and retaining health workers in rural positions that need to be addressed in the next two years?
Section Four: Coordination and Integration	
9 a)	In what ways has coordination and synergy of HIV/AIDS, MNCH, Nutrition, FP, and Malaria services provided by stakeholders (MOH, USG, other donors, private sector health facilities, etc.) in ZISSP target districts been strengthened?
b)	Which of the above health services have been integrated in Health Facility at provincial level?
c)	Which of the above services have been integrated at Health Facility at district level?
d)	What are key challenges in integrating or coordinating health services across the 5 areas
10	In what way, if at all, has ZISPP facilitated coordinated planning at provincial, district, and/or HF level?
11	In what way, if at all, have multi-disciplinary clinical care teams strengthened coordination of services at provincial, district, and/or health facility level?
12 a) b) c)	What could ZISSP do in the remaining project period to further strengthen integration, coordination and/or synergies among other health services: At national level: At provincial level: At district level:
Section Five: Country Ownership	
13.	What is the perception of MOH and NMCC regarding ZISSP seconded staff's role in building capacity of Government of the Republic of Zambia (GRZ) counterparts to plan, design, implement, manage, monitor and evaluate health programs at the national, provincial and district levels?

14.	How would you assess the ZISSP seconded staff's role in building your colleagues' capacities to plan, design, implement, manage, monitor and evaluate health programs?
15.	How do you rate the specialists in these specified areas?
16	What are the most important issues for which the respective specialists are responsible that need to be addressed in the next two years? Clinical Care Specialist; Management Specialist; Community Health Coordinator Specialist;
Section Six: Gender Integration	
17.	To what extent have women been empowered to take action in support of health behaviors and interventions in ZISSP target districts? [*Participation as volunteers, Leadership roles in community groups, participation in community health planning, participation in distance radio learning program*]

Key informant Interview Questions for Development and USAID Partners

INSTRUCTIONS

Thank you very much for taking time to participate in the ZISSP program evaluation interview. My name is_____ and I will be asking you some questions which will guide the interview process. The information provided will be handled with confidentiality. Please limit your response to specific activities related to the ZISSP program.

The questionnaire is focused on interventions on ZISSP's Health System Strengthening activities and include focus areas of Family Planning, HIV/AIDS, MNCH, malaria and nutrition. Both open and closed ended questions are included in the questionnaire. The closed ended questions have instructions for ticking the appropriate option, and providing descriptive information when requested to list and specify. You are required to provide descriptive information for all open ended questions.

Section One: Background information

Date:_____
Level_____
District:_____
Title of Respondent _____ **Sex:** Male____ Female_____
Program Area (if applicable):_____

Enumerators name:_____

Open Question: Can you name the focus activities of the ZISSP project? In general, can you name where they are implementing their activities? [Listen for national level, Provinces (name if they can), Districts (name if they can), pre-service institutions, health facilities, community level)

Section one: Progress towards results	
1.1	Have you partnered with ZISSP to strengthen in access to and/or utilization of family planning, HIV/AIDS, malaria, MNCH and nutrition information and services in ZISSP target districts? If yes, please describe all key activities that your organization has carried out through ZISSP. *Insert checklist: FP, HIV/AIDS, malaria, MNCH (EmONC, SMGL, CCM, EPI), nutrition, training, supportive supervision, clinical mentoring, community level activities (specify), grants support, QI, Program Performance Review, Management and Leadership, National Health Accounts Survey and Resource Mapping, Provincial Statistics Bulletins, Management and Use of Data, Performance Management, Financial Management, many malaria activities, add all?,* community resource mapping, community health planning, SMAGs, NHCs CHACs, other.
1.2	Based on this experience, what in your view are the key challenges in improving access to and utilization of health services across the 5 above technical areas in Zambia?
1.3	What can ZISSP do between now and end of 2014 to ensure that improvements in access to and utilization of health services will be sustained after the project ends?
1.4	Between now and end of 2014, what are most important issues that ZISSP needs to address in building capacity to improve access to/utilization of health services in target districts?
Section two: Capacity Building	
	Evaluation Question: Progress to strengthen capacity of MOH/MCDMCH and NMCC staff at national, provincial, and district level to plan, design, implement, manage, monitor and evaluate health programs within each of the five program areas: HIV/AIDS, malaria, family planning (FP), maternal, newborn and child health (MNCH) and nutrition)?
2.1	Do you know of any ZISSP activities that are strengthening capacity at national level to plan, manage, supervise and evaluate delivery of health services nationwide? Please explain your answer and give examples.

	At Provincial Level? At District Level? In Health Facilities? At Community Level?
	If you identified capacity strengthening at community level. Has ZISSP helped to improve community involvement in health (behaviors, planning, demand for service) in targeted districts? If yes, Please explain your answer and give examples.
2.3	Do you know of any ways that ZISSP has addressed gender and/or increased the involvement and leadership of women in health related activities at any or all levels (national, provincial, district, HF, community)? If yes, please provide examples.
2.4	What have been the key challenges for your organization in implementing integrated programs in Family Planning, HIV/AIDS, MNCH, malaria and nutrition?
2.5	Can you name any particular ZISSP accomplishments in the above named sectors, or in health system strengthening overall?
2.6	What in your view could ZISSP do in the remaining project period (to end of 2014) to position the MOH/MCDMCH or NMCC to sustain capacities that have been built

	through its partnership with GRZ?
Section three: Human Resources for Health	
3.1	What role, if any, do you know that ZISSP has played to strengthen MOH/MCDMCH/NMCC capacity to attract and retain health workers in rural positions and areas?
	Are you familiar with the ZISSP seconded positions at the national and provincial levels? [If no, skip this question.] If yes: In your view, how have the positions seconded by ZISSP to MOH at national and provincial levels (and at district level for SMGL) helped to build capacity among MOH/MCDMCH/NMCC? (Can ask for each of the 3 main categories: CCS, MS, CHCS, or at national level.)
Section four: Coordination and Integration	
4.1	Has your organization partnered with ZISSP to strengthen coordination and synergy of HIV/AIDS, MNCH, Nutrition, FP, and Malaria services in project target districts? With what results? How have you measured results?
Section 4: Country Ownership	
5.1	If you identified ZISSP contributions to MOH/MCDMCH/NMCC increased GRZ capacity in earlier questions, do you think any of this capacity will be sustained after ZISSP ends? Why or why not?

5.2	What in your view does ZISSP need to focus on most in the remaining project period (to end of 2014) to ensure that project achievements can be sustained?
Thank you for your time and the information you have shared. Reiteration of how information will be used. Provide contact details in case interviewee has any questions after interview.	

One-On-One Interview Questionnaire for Health Workers and Managers Who Have Received ZISSP Supported Training

Introduction:

Thank you for taking time to participate in the ZISSP program evaluation interview. My name is_____ and I will be asking you some questions which will guide the interview process. The information provided will be handled with confidentiality.

The questionnaire comprises three sections: capacity building, human resources for health, and community participation in health. Both open and closed ended questions are included in the questionnaire. The closed ended questions have instructions for ticking the appropriate option, and providing descriptive information when requested to list and specify. Please provide descriptive information for all open ended questions.

Background information
Date:_____
District:_____

Title of Respondent _____ **Gender:** Male____ Female_____

Program Area (if applicable):_____

Enumerators name:_____

Section One: Capacity Building

What ZISSP sponsored trainings or workshops that are intended to build capacity to plan, design, manage and monitor and evaluate health programs have you directly participated in, if any?

1.1_____
1.2_____
1.3_____
1.4_____
1.5
1.6Other:_____

Do you believe that these workshops have helped to build your capacity, as intended?

2.1 If Yes, in what ways?

2.2 If No, why not?

Did the training offer ideas and skills that you would like to introduce in your health facility?

3.1 If yes, please provide at least two examples of these new ideas and skills.

More specifically, what contributions have ZISSP supported trainings made to improve your skills in (Ask about activities one by one, and record response):

4.1Program planning

4.2 Program design

4.3 Program management

4.4 Implementing HIV/AIDS, safe-motherhood, child health and nutrition, family planning and malaria activities

4.5 Supportive supervision

4.6 Clinical mentoring

4.7 Performance appraisal or other HR functions

4.8 Monitoring and Evaluating program activities

4.9 Collecting, analyzing and utilizing data

4.10 Other (please specify)

What else might ZISSP do in the remaining project period (between now and December 2014) to further build capacity at health facilities and/or ensure that capacity already built will be sustained after the project ends?

Section Two: Human Resources for Health

Are you aware of the Zambia Health Worker Retention Scheme (ZHWRS)?

If yes, are you enrolled in it?

What is your overall impression of how effectively the retention scheme is managed? (this question is for Health Workers representing target districts only)

In your view, are these benefits provided in a timely manner?

Do you consider the incentives provided through the ZHWRS adequate to retain health workers? Please explain your answer.

Would you say that management of the ZHWRS improved, remained the same, or deteriorated in the past two years? Please explain your answer.

Section Three: Community Participation in Health
If possible, please provide specific examples of ways in which community participation in improving health practices is stronger as a result of ZISSP activities in the district. (if no answer, prompt for BCC, NHCs, CHAs, SMAGs, SMGL, CBD, nutrition volunteers, adolescent health volunteers, community involvement in health planning). To the best of your knowledge, were representatives of communities involved in developing the National Health Strategic Plan, 2011-2016? Are you aware of any community based organizations in this district that have received a grant from ZISSP? If so, do you know what activities they are implementing with the grant, if any? In your view, what are the most important issues related to improving health at local level (if no answer, prompt for access to services, demand for services, information and education, behavior change, other)? What suggestions do you have, if any, for how ZISSP might help to improve community participation in improving health practices in the remaining project time period

Thank you for your participation.

Key Informant Interview with Provincial and District Staff – MALARIA MANAGERS ONLY

INSTRUCTIONS

Thank you for taking time to participate in the ZISSP program evaluation interview. My name is_____ and I will be asking you some questions which will guide the interview process. The information provided will be handled with confidentiality. Please limit your response to specific activities related to the ZISSP program.

The questionnaire is focused on interventions against malaria. Both open and closed ended questions are included in the questionnaire. The closed ended questions have instructions for ticking the appropriate option, and providing descriptive information when requested to list and specify. You are required to provide descriptive information for all open ended questions.

Background information
Date:_____ **Level**_____ **District:**_____ **Title of Respondent** _____ **Sex:** Male____ Female_____ **Program Area (if applicable):**_____ **Enumerators name:**_____

Section One: Progress towards results	
	With reference to the table below, the changes between 2010 and 2012 are marginal, compared to the previous periods. What are your views on that?
	It is generally expected for most phenomenon that progression would be slow in the top levels. Is that something you were expecting in IRS and IPT?
	What are the positives in behavior change communication activities related to malaria, if any?
	In IRS which is an area of focus by ZISSP, what are the challenges in attaining higher near universal coverage?
	In IPT which is an area of focus by ZISSP, what are the challenges in attaining higher near universal coverage?

Facility Service Delivery Capacity Checklist

HF questions will be selected from the list below based on type of facility and ZISSP focus in that Province.

Introduction

Thank you for participating in the ZISSP mid-term evaluation interview. This question will collect information on the capacity that has been built for this facility. It has 4 sections, background information, service delivery general capacity, service delivery specific capacity and service utilization. Most of the questions are closed ended, with a few where you may have to give descriptive information and statistics.

Section One: Background Information				
Facility Name_____				
Province _____ **District**_____				
Level of Care_____				
Title of Respondent (s) Interviewed at Health Facility:				
Title			**Gender (tick)**	
			Male	**Female**
Section Two: Service Delivery Capacity				
01	In your own opinion, do you think the ZISSP project has contributed towards making improvements in increasing human resources for health?		**Yes**	**No**	**Comments**
05	If yes, what is the minimum staffing requirement for this facility, according to the national MOH establishment?			
	Position	**Establishment**	**Available**	**State how many are supported through ZHWRS**
	Doctors			
	Registered nurse midwives			
	Registered Nurses			
	Enrolled Nurse midwives			
	Enrolled Nurses			
	Clinical Officers			
	Environment Technologist			
	Laboratory Technician			
	Pharmacy technician			
	Other Specify:			

06	How many health workers are on duty today?	Available	State how many are supported through ZHWRS program
	Doctors		
	Registered nurse midwives		
	Registered Nurses		
	Enrolled Nurse midwives		
	Enrolled Nurses		
	Clinical Officers		
	Environment Technologist		
	Laboratory Technician		
	Pharmacy technician		
	Other Specify:		
	Which volunteers work with this facility? Please list , and specify what their roles and responsibilities are:		

08	In your own opinion, do you think ZISSP has contributed to improvements in provision of Child health and nutrition Services:			
	Child Health and Nutrition	**Yes**	**No**	**Comments**
	IMCI services			
	Immunizations			
	Community-based growth monitoring promotion			
	Community based IYCN			
09	Do you have guidelines governing the provision of the services above?	Yes	No	Comments
	If yes, request to see a copy of the guideline and write finding under comment.			
10	Do you have staff and volunteers that are trained in IMCI?	Yes	No	Comments
11	If Yes specify how many, categorized by type of cadre			
	Cadre	Number Trained		Comments
	Doctors			
	Nurses/midwives			
	Clinical Officers			
	Volunteers ***(specify type under comment column)***			
	Other, Specify			
12	If No, state the reason why?			
13	In your own opinion, do you think ZISSP has contributed to improvements in provision of the following Family Planning Services:			

		Yes	No	Comments
	Pill			
	Injectables			
	IUCD			
	Implants			
	Condoms			
	Permanent methods (Tubal Ligation/vasectomy)			
17	Does this facility support community-based distributors of FP services?	**Yes**	**No**	**Comments**
18	If Yes, how many trained CBDs do you have at community level?	**Total Number**		
19	Who trained the CBDs?	**Yes**	**No**	**Comments**
	ZISSP/MOH			
	Other NGOs ***(Specify names in comment column)***			
20	Do you follow any national guidelines/protocols for provision of FP services?	**Yes**	**No**	**Comments**
21	If yes, which guidelines are these? ***(List responses in comment column) Request to see the documents and write finding in comment column***			
22	Do you have staff that is trained in FP?	**Yes**	**No**	**Comments**
23	If yes, How many are they?			
	Cadre	**Yes**	**No**	**comments**
	Doctors			
	Nurses/midwives			
	Clinical Officers			
	Community Volunteer			
	Other Specify			
24	In your own opinion, do you think ZISSP has contributed to the improvement in provision of the following EmONC services?			
		Yes	**No**	**Comments**
	Administration of antibiotics for infection			
	Administration of oxytocin			
	Administration of antihypertensive and anticonvulsant medication for preeclampsia			
	Manual removal of placenta			
	Assisted vaginal delivery			
	Perform surgery (e.g., caesarean section)			
	Perform basic neonatal resuscitation (e.g., with bag and mask)			
	Perform Blood transfusion			

25	How many health workers are trained in EmONC?			
	Cadre	**Number trained**		
	Doctors			
	Nurses/midwives			
	Clinical Officers			
	Other, specify			
	How many trained SMAGs do you have and/or support at this facility?			
27	Who supervises the SMAGS?			
28	How often is supervision done? ***(request to see a support supervision report)***			
29	How are women in labor transported to the health facility?			
30	Do you have a maternal waiting home at this facility?	**Yes**	**No**	**Comments**
31	On average, how many women utilize the maternal waiting home in a month?			
	Is this facility attached to a Maternal Death Review Committee?	Yes	No	Comments
	What process do you follow when reporting a maternal death?			
32	Do you have policies, guidelines and protocols that you follow in provision of EmONC services?	**Yes**	**No**	**Comments**
	Adolescent reproductive Health strategy			
	MOH implementation plan			
	Misoprostol guideline/protocols			
	RED Strategy			
	BCC framework			
	QI operational guide			
	Other, specify			
33	In your own opinion, do you think ZISSP has contributed to the improvement in provision of the following malaria control services?	**Yes**	**No**	**Comments**
	Provide Intermittent preventive treatment (IPT) to pregnant women			
	Support Indoor residual spraying (IRS)			
	Treat malaria cases			
	Other, specify			
34	Do you have health workers and volunteers that are trained to implement malaria activities?	**Yes**	**No**	**Comments**
35	If yes, in which aspects?			
	Integrated Community based Case management (ICCM)			
	IRS			
	Entomological monitoring			
	Management of insecticide poisoning			
	Other, specify			

36	Do you use any guidelines in implementation of Malaria activities?	**Yes**	**No**	**Comments**
37	If yes, which guidelines?	**Yes**	**No**	**Comments**
	IRS technical guidelines			
	Malaria treatment guidelines			
	QI operational guidelines			
	Environmental mitigation plan			
	Other, Specify			

Community Health Assistant Questionnaire

Community IDENTIFICATION

Number of CHAs at the Health Post (HP):____

Estimated Distance from the HP to Parent Health Centre:____

Note: This is a self-administered questionnaire. Please answer all questions independently with consulting another person. The information you will provide cannot be identified with you – but will be used in improving future support to the CHA programme.

SECTION 1: GENERAL INFORMATION ABOUT THE COMMUNITY HEALTH ASSISTANT

#	QUESTIONS	RESPONSE CATEGORIES	RESPONSE
101	What is your gender?	1-Female 2-Male	
102	Since the time you graduated, have you performed functions as Community Health Assistant?	Yes No**(➔END INTERVIEW)**	
103	For how many months have you worked before you came to this refresher training since graduation?		__ __ months
104	Do you have another health worker at your health post, other than a CHA.	Yes No**(➔GO TO 201)**	
105	What is the title of this health worker (select all that apply if more than one)	Clinical Officer Environmental Health Technologist Health Assistant Nurse, Other (Specify) _____	

SECTION 2: WORK EXPERIENCE TODATE

#	QUESTIONS	RESPONSE CATEGORIES	RESPONSE

#	QUESTIONS	RESPONSE CATEGORIES	RESPONSE
201	Where have you spent much of your time since you graduated	1-Health post 2-Community	
202	Have you received any supervision since you went back to your posting?	Yes No**(➔END INTERVIEW)**	
203	How many times have you been visited for supervision?		__ __ # of times
204	For each of the visits (starting with the most recent), please state the month of visit, title of the supervising officer and the office they came from (e.g. health centre, district, etc.)		
	(i) Month of visit	(ii) Title of officer	(iii) Name of the office
204A			
204B			
204C			
204D			
204D			
205	How many of these visits were exclusively for checking on the CHA programme?		__ __ # of times
206A	Is the supervisor at your parent facility trained on how to provide support to you?	Yes No Do Not Know	
206B	Have you received any supportive visit from this supervisor?	Yes No	
206C	How many of these visits has the supervisor provided you with this support?		__ __ # of times
207	How do you rate the quality of the supervision conducted by your supervisor (from the parent health facility)?	Excellent Good Average Poor Very poor	
208	What recommendations would suggest improving the supervision process?		

Thank you for your time and cooperation.

LIKERT SCALE QUESTIONNAIRE

Zambia Integrated Systems Strengthening Programme
Evaluation Survey

--2013 Mid-Term Evaluation—

Zambia Integrated System Strengthening Programme (ZISSP)
-- Mid-Term Evaluation Questionnaire--

STANDARDISED PERCEPTION TOWARDS THE ZISSP INTERVENTIONS

This questionnaire is intended to provide a standardized perception of ZISSP contributions. It covers the six key areas of the ZISSP evaluation.

Please do not respond for other projects interventions. The focus is on ZISSP. Particularly, do not mix in things from the Health Systems Strengthening Programme (HSSP) which was implemented by the same organization now implementing ZISSP

Please do not complete questions for which you lack information – other respondents may handle those. Please confer with other individuals as you wish, and answer the items simply in your personal capacity, giving your own best judgment. All responses are entirely confidential.

Thank you for your assistance with this evaluation.

INSTRUCTION FOR FILLING OUT

Mark the number indicating the level of your perception with an X in any color of a pen if answering a hard copy questionnaire. You will hand the questionnaire to someone who would introduce herself or himself appropriately.

Shade the box with pink if answering a soft copy questionnaire. Then save it under the same file name and email it back to the senders email.

To give a summary picture of the contributions of the ZISSP Project, please rate the following items. Score each item from 1 to 10, where 1 represents non-existent or very weak effort and 10 represents extremely strong effort. Try to answer each item; omit it only if you lack information.

Component	Description	1= Non-existent to 10= Extremely strong									
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Progress made towards improving access to and utilization of family planning, HIV/AIDS, malaria, MNCH and nutrition information and services in ZISSP target districts?											
Coverage in In-Door Residual Spraying	Extent of coverage for ZISSP/Akros supported In-Door Residual Spraying in the area of your jurisdiction	1	2	3	4	5	6	7	8	9	10
	How much more households should be sprayed in each round of spraying in order to achieve the target coverage?	1	2	3	4	5	6	7	8	9	10
Challenges in the In-Door Residual Household Spraying	Extent of problems in the ZISSP/Akros supported In-Door Residual Spraying in the area of your jurisdiction	1	2	3	4	5	6	7	8	9	10
	To what extent does the planning, management and stakeholder consensus for the In-Door Residual Spraying need improvement?	1	2	3	4	5	6	7	8	9	10
Maternal, New-born and Child Health	Extent of improvement in Maternal New-born, and Child Health and nutrition in the area of your jurisdiction	1	2	3	4	5	6	7	8	9	10
	To what extent should this be improved in order to attain the planned targets?	1	2	3	4	5	6	7	8	9	10
Nutrition	Extent of improvement in infant and young child feeding practices including breastfeeding in the area of your jurisdiction	1	2	3	4	5	6	7	8	9	10
	To what extent should this be improved, for example to achieve universal exclusive breastfeeding and other best infant and child feeding practices?	1	2	3	4	5	6	7	8	9	10
Reduction in child mortality	Extent of your perception of any reduction in child mortality since 2010.	1	2	3	4	5	6	7	8	9	10
	What is the extent of reduction needed in order to achieve the target in the places of your jurisdiction?	1	2	3	4	5	6	7	8	9	10

Component	Description	1= Non-existent to 10= Extremely strong									
		1	2	3	4	5	6	7	8	9	10
Progress made to strengthen the capacity of MOH and NMCC staff at each level to plan, design, implement, manage, monitor and evaluate health programs within the five programme areas											
Coverage of the Zambia Management and Leadership Academy (ZMLA)	Extent of participation in the ZMLA by personnel in the area of your jurisdiction	1	2	3	4	5	6	7	8	9	10
	To what extent should more health sector personnel in your area participate in the ZMLA in order to have enough skilled personnel in management, planning and problem identification in delivering health care services?	1	2	3	4	5	6	7	8	9	10
Improvement in programmes performance and management of health facilities due to the (ZMLA)	Extent of improvement in performance of programmes including non-ZISSP ones due to the ZMLA	1	2	3	4	5	6	7	8	9	10
	To what extent have problems like stock-outs, expiration of drugs been reduced?	1	2	3	4	5	6	7	8	9	10
Malaria Information System	Reliability of data on the number and places where Insecticide Treated nets (ITNs) are distributed and In-Door Residual Spraying (IRS) was done	1	2	3	4	5	6	7	8	9	10
	To what extent should the databases for distribution of ITNs, IRS, active case surveillance and GIS be improved to provide reliable and trusted outcomes of malaria interventions?	1	2	3	4	5	6	7	8	9	10
Development of databases for the malaria programme	Extent to which databases have been developed for recording number, type, place and time of distributing Insecticide Treated Nets and, In-Door Residual Spraying.	1	2	3	4	5	6	7	8	9	10
	How much more work has to be done to have database protocols, data quality assurance systems and universal coverage?	1	2	3	4	5	6	7	8	9	10
National Health Accounts	Extent of capacity (both skills and databases) of retrospective expenditure data to compile national health accounts showing how resources are utilized in the health sector.	1	2	3	4	5	6	7	8	9	10
	To what extent should the skills, financial records, stocks records and expenditure skills be improved in order to produce National Health Accounts without external support?	1	2	3	4	5	6	7	8	9	10

Component	Description	1= Non-existent to 10= Extremely strong									
		1	2	3	4	5	6	7	8	9	10
Ways in which the Ministry of Health's capacity to attract and retain health workers in rural positions improved											
Accessing the incentives on the Zambian Health Worker Retention Scheme	Extent to which the scheme can be accessed by eligible health workers	1	2	3	4	5	6	7	8	9	10
	How easy is it for health workers to meet the requirements and access the benefits under this scheme?	1	2	3	4	5	6	7	8	9	10
Incentives in the Zambian Health Worker Retention Scheme	Adequacy of incentives on the Zambian Health Worker Retention Scheme	1	2	3	4	5	6	7	8	9	10
	To what extent should the coverage of the incentives support provided by ZISSP be increased in order to be adequate given the number of eligible health workers?	1	2	3	4	5	6	7	8	9	10
Staffing in remote rural health centres	Extent of improvement in staffing in rural health facilities since introduction of the Zambian Health Workers Retention Scheme	1	2	3	4	5	6	7	8	9	10
	To what extent can changes in staffing in remote rural health centres be attributed to the Zambian Health Worker Retention Scheme?	1	2	3	4	5	6	7	8	9	10
Improvements in medical supplies and equipment in rural health facilities	Extent of reduction in frustrations by health care personnel due to an improvement in medical supplies and equipment	1	2	3	4	5	6	7	8	9	10
	To what extent do medical supplies and equipment still need to be improved in rural health facilities?	1	2	3	4	5	6	7	8	9	10
Improvement in rural livelihood conditions	Extent of improvement in living conditions such as housing, shops, transport, phone, radio and television reception	1	2	3	4	5	6	7	8	9	10
	To what extent should improvements in livelihood conditions be attained to reduce the exodus of health care personnel?	1	2	3	4	5	6	7	8	9	10
Salaries and overall conditions of service for health personnel	Extent to which salaries and overall conditions of service for health personnel have improved since the inception of the scheme	1	2	3	4	5	6	7	8	9	10
	To what extent should the salaries and overall conditions of service for health care personnel be improved in order to retain them at their postings?	1	2	3	4	5	6	7	8	9	10

Component	Description	1= Non-existent to 10= Extremely strong									
		1	2	3	4	5	6	7	8	9	10
Perceptions of health workers who are currently on the Zambia Health Worker Retention Scheme about how effectively it is managed											
Awareness about the scheme and its package of incentives	Extent of awareness about the existence of the scheme and the package	1	2	3	4	5	6	7	8	9	10
	To what extent should the scheme be publicised so that all health workers in rural areas or those intending to work in remote areas be made aware about the compensations for hardship offered under the scheme?	1	2	3	4	5	6	7	8	9	10
Incentives of the scheme	Adequacy of incentives of the scheme	1	2	3	4	5	6	7	8	9	10
	To what extent should the package of incentives be improved?	1	2	3	4	5	6	7	8	9	10
Applying for the scheme	Ease of applying for the scheme	1	2	3	4	5	6	7	8	9	10
	To what extent should the application process be improved?	1	2	3	4	5	6	7	8	9	10
Management of the scheme	Rating of how well the scheme is managed	1	2	3	4	5	6	7	8	9	10
	To what extent should the management of the scheme be improved?	1	2	3	4	5	6	7	8	9	10
Access to the scheme by ineligible personnel	Extent to which health workers that are not eligible to be on the scheme are enrolled for the scheme	1	2	3	4	5	6	7	8	9	10
	To which extent are targeted health workers that are not on the scheme being put on the scheme?	1	2	3	4	5	6	7	8	9	10
Influence of the Zambia Health Worker Retention Scheme in your retention	Extent to which the scheme influenced your current stay	1	2	3	4	5	6	7	8	9	10
	To what extent would the scheme continue to influence your stay in the current position?	1	2	3	4	5	6	7	8	9	10

Component	Description	1= Non-existent to 10= Extremely strong									
		1	2	3	4	5	6	7	8	9	10
Coordination and synergy of HIV/AIDS; Maternal Newborn and Child Health; Nutrition; Family Planning and Malaria services provided by stakeholders in ZISSP target districts											
Coordination	Extent to which ZISSP seconded staff have contributed to the coordination and leverage of support from various cooperating partners in the health sector	1	2	3	4	5	6	7	8	9	10
	To what extent can ZISSP project and ZISSP personnel improve the coordination of support to the health sector among cooperating partners?	1	2	3	4	5	6	7	8	9	10
Synergy	Extent to which ZISSP initiatives have been peer reviewed by the Technical Working Groups and other Committees	1	2	3	4	5	6	7	8	9	10
	To what extent should ZISSP improve its relationship with the partners in the technical working groups and other committees?	1	2	3	4	5	6	7	8	9	10
National Ownership-Collaboration during implementation of activities	Extent to which ZISSP utilises existing structures to implement activities such as In-Door Residual Spraying?	1	2	3	4	5	6	7	8	9	10
	To what extent should ZISSP supported initiatives increase the utilisation of existing structures during implementation?	1	2	3	4	5	6	7	8	9	10
Zambia Management and Leadership Academy (ZMLA) Programme	Extent to which the programme has improved performance in achieving targets and delivering health services	1	2	3	4	5	6	7	8	9	10
	To what extent should the ZMLA programme be implemented among the staff?	1	2	3	4	5	6	7	8	9	10
Clarity of intent, timeline and memorandum of support by ZISSP	Extent to which ZISSP indicates the areas it can support where and when	1	2	3	4	5	6	7	8	9	10
	To what extent should ZISSP improve its communication of intent and timing of support to activities in national and sub-national plans, strategies and programmes?	1	2	3	4	5	6	7	8	9	10

Component	Description	1= Non-existent to 10= Extremely strong									
		1	2	3	4	5	6	7	8	9	10
Perception of Ministry of Health and National Malaria Control Centre regarding ZISSP seconded staff role in-building the capacity of GRZ counterparts to plan, design, implement, manage, monitor and evaluate health programs at the national, provincial and district levels											
Mentorship	Extent to which mentorship from ZISSP seconded staff has improved the skills of their mentees (counterparts)	1	2	3	4	5	6	7	8	9	10
	To what extent should the mentorship component from ZISSP seconded staff be improved?	1	2	3	4	5	6	7	8	9	10
Coordination	Extent to which ZISSP seconded staff have contributed to the coordination and leverage of support from various cooperating partners in the health sector	1	2	3	4	5	6	7	8	9	10
	To what extent can ZISSP seconded staff improve the coordination of support to the health sector among cooperating partners?	1	2	3	4	5	6	7	8	9	10
Skills	Extent to which ZISSP seconded staff are skilled in the areas they are working.	1	2	3	4	5	6	7	8	9	10
	To what extent should the skills of ZISSP seconded personnel be improved?	1	2	3	4	5	6	7	8	9	10
Design, development and implementation of programmes	Extent to which ZISSP seconded staff have supported MOH, MCD/MCH and NMCC for programme strategies, management and development of databases for monitoring and evaluation	1	2	3	4	5	6	7	8	9	10
	To what extent should ZISSP personnel continue offering support for programme strategies, management and development of databases for monitoring and evaluation?	1	2	3	4	5	6	7	8	9	10
Monitoring implementation of interventions at community level	Extent of implementing monitoring and evaluation strategies for activities at community level in the area of your jurisdiction	1	2	3	4	5	6	7	8	9	10
	How much more should ZISSP do to improve the monitoring and evaluation of activities at community level?	1	2	3	4	5	6	7	8	9	10
Linking community based service deliver to higher level service delivery	Extent to which ZISSP activities have improved linkages between the community based service delivery and the next level of the health care delivery	1	2	3	4	5	6	7	8	9	10
	To what extent should the linkages be improved?	1	2	3	4	5	6	7	8	9	10
Component	**Description**	**1= Non-existent to 10= Extremely strong**									
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Component	Description	1= Non-existent to 10= Extremely strong									
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Extent to which women been empowered to take action in support of health behaviours and interventions in ZISSP target districts											
Gender roles in health	Extent to which gender roles are detrimental to the health of mothers, children, spouses and their families	1	2	3	4	5	6	7	8	9	10
	Gender stereotyping refers to the way that society expects women and men to behave and the roles they are expected to play. Have ZISSP interventions changed gender stereotyping such that women in the communities make an increasing number of decisions and or take actions which will affect their health and that of their children, spouses and their families?	1	2	3	4	5	6	7	8	9	10
Extent to which women participate in leadership of community health structures	Extent to which women's leadership of community health structures is accepted	1	2	3	4	5	6	7	8	9	10
	Has there been an increase in the number of women taking up leadership positions in SMAGs, Radio Listening Groups, Health Centre Advisory and Neighbourhood Health Committees?	1	2	3	4	5	6	7	8	9	10
Planning for gender integration	Extent to which annual health plans at community, facility, district and provincial level incorporate gender issues	1	2	3	4	5	6	7	8	9	10
	Has there been an increase in the consideration of gender mainstreaming in your annual work plans?	1	2	3	4	5	6	7	8	9	10
Budgeting for gender integration	Extent to which annual budgets at community, facility, district and provincial level incorporate gender issues	1	2	3	4	5	6	7	8	9	10
	Has there been an increase in the allocation of funds in the budget of your activities towards gender mainstreaming?	1	2	3	4	5	6	7	8	9	10
Monitoring gender integration	Extent to which gender integration is monitored in the monitoring and evaluation plan	1	2	3	4	5	6	7	8	9	10
	To what extent should more indicators be added to monitor integration of gender in health interventions?	1	2	3	4	5	6	7	8	9	10

Final Questions:

A. Did you answer this questionnaire with other colleagues? Yes __ No___

B. How long have you been closely acquainted with the ZISSP Programme?

_____ years

C. During most of this time, what has your relationship been to the programme?

D. State whether you are an employee of ZISSP or not by marking with an "X" in the appropriate box:

	TICK IN BOX BELOW		**TICK IN BOX BELOW**
YES		**NO**	

E. Work station

Code	**Placing or description of respondent**	**Mark with an "X" to indicate location of office**	**Write name of district**
1.	ZISSP Headquarters		
2.	ZISSP Employee seconded to a GRZ Ministry at National Level		
3.	ZISSP Employee seconded to a GRZ Ministry at Provincial Level		
4.	ZISSP Employee seconded to a GRZ Ministry at District Level		
6.	Non-ZISSP Employee at GRZ Ministry Headquarters		
7.	Non-ZISSP Employee at Provincial Level		
8.	Non-ZISSP Employee at District Level		
9.	Non-ZISSP Employee at GRZ Ministry at Community Level		
10.	Non-ZISSP Employee of a ZISSP Programme partner		
11.	Beneficiary on the Zambia Health Worker Retention Scheme		
12.	Other		

F. Any final comments or suggestions?

_____

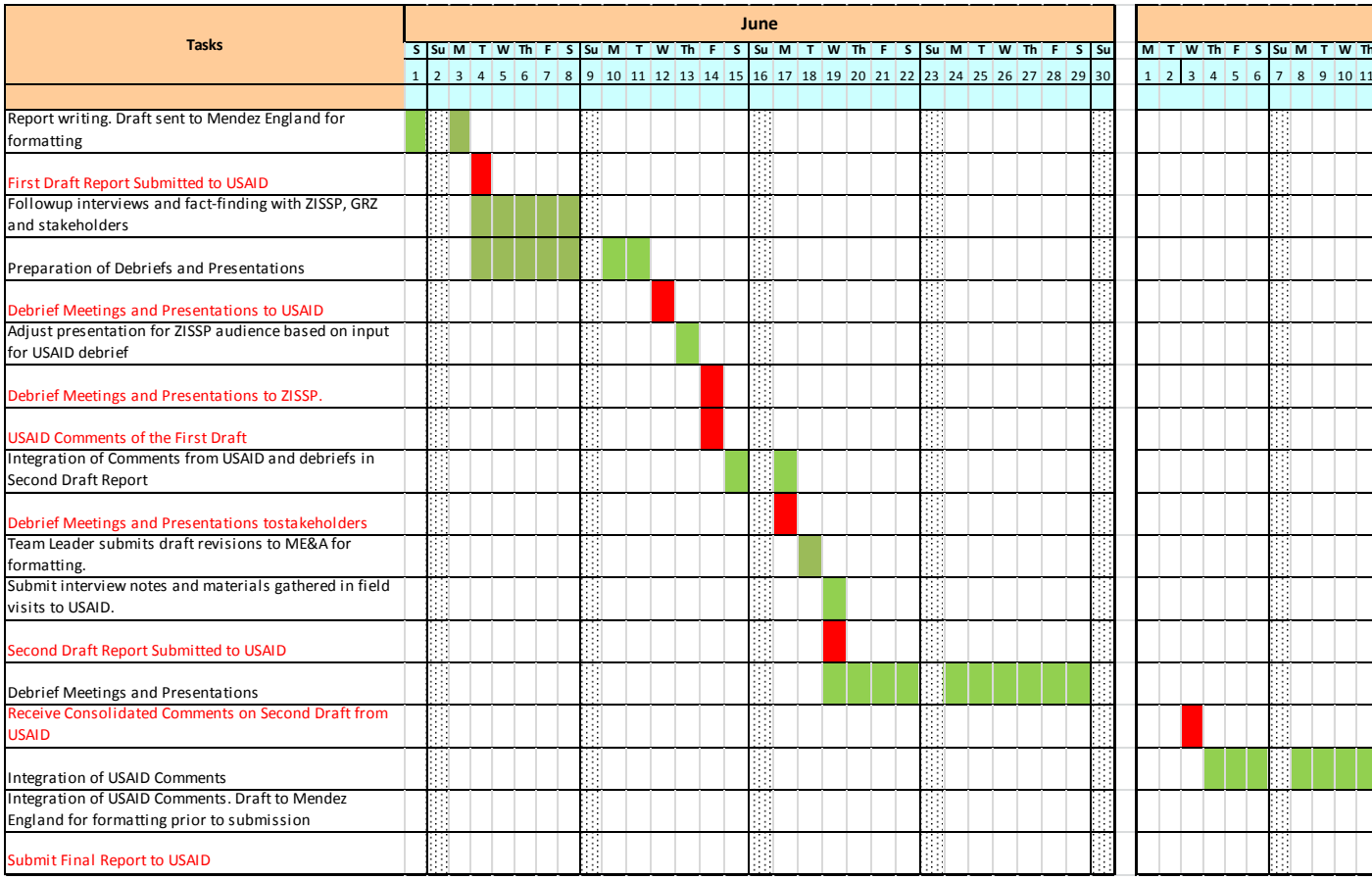
_____

_____

ANNEX IV: FINAL EVALUATION SCHEDULE

Tasks	April																														
	M	T	W	Th	F	S	Su	M	T	W	Th	F	S	Su	M	T	W	Th	F	S	Su	M	T	W	Th	F	S	Su	M	T	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
Team Travel to Zambia																															
In-Briefing with USAID, Implementing Partner and GRZ																															
Team Planning Meeting																															
ZISSP activity mapping exercise																															
Field Visit planning																															
Evaluation Tool Development																															
Team input on Revised Workplan																															
Meetings with ZISSP for project overview Plan ZISSP sector-specific briefings. Plan field visit to																															
Team Planning Meeting																															
Evaluation tools development																															
Review documents and data provided by ZISSP. Field visit planning.																															
ZISSP Sector Specific Briefings in Human Resources for Health, EMNOC, Adolescent Health, Family Planning,																															
ZISSP briefings on Clinical Care, Management and Community																															
ZISSP program specific briefings in Child Health and Nutrition, Malaria, PMP and Gender																															
Team Planning Meeting Review Documents, Reports, Studies and Guidelines provided by ZISSP																															
Interview ZISSP Training and Capacity Building Staff. Briefing on Quality Improvement																															
Interviews with Stakeholders/ Key Informant Interviews (KII)																															
Interviews with Stakeholders/Key Informant Interviews																															
Interviews with Stakeholders/Key Informant Interviews																															
Interviews with Program Partners and Stakeholders																															
Team 1: In Choma to meet PMO, 3 ZISSP-seconded staff and IMCI trainers																															
Team 2: In Ndola to meet PMO , 3 ZISSP-seconded staff and GRZ programme officers																															
Team 1: Interviews with Kalomo DHO staff																															
Team 1:Interviews with Sipatunyana RHC Staff and the Mumuni Centre Subgrantee																															
Team 2: Masaiti - Interviews with DHO staff																															
Team 1:Interviews with Namwianga Zonal RHC Staff and SMAG members around Luyaba RHC																															
Team 2: Masaiti - Interviews with Fiwale and Kafulafuta GRZ RHC staff and; NHC representatives in Kafulafuta																															
Team 1:Interviews with Sinazongwe DHO staff																															
Team 2: Interviews with Luanshya DHO and COIEP Subgrantee																															
Team 1:Interviews with Sinamalima RHC Staff																															
Team 1:Interviews with Sulwegonde RHC Staff and Siatwiinda RHC Staff																															
Team 2: Interviews at Kafubu Block with facility staff and SMAGs																															
Team 1:Interviews with Maamba General Hospital - QI Team and Gwembe with DHO Staff																															
Team 2: Interviews with Roan DEM turors; Luanshya DHO and COIEP Subgrantee and Ndola PHO																															

Tasks	May																														
	W	Th	F	S	Su	M	T	W	Th	F	S	Su	M	T	W	Th	F	S	Su	M	T	W	Th	F	S	Su	M	T	W	Th	F
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Team 1:Interviews with Munyumbwe RHC Staff																															
Team 1: Mop-up Interviews in Gwembe with DHO Staff																															
Team 2: Lufwanyama: Interviews with DHO staff and St. Joseph RHC staff																															
Team 1: Return to Lusaka																															
Team 2: Lufwanyama: Interviews with DHO staff and with clients, staff and volunteers at Mibenge HP																															
Team 2: Travel to Kabwe																															
Team 1:Courtesy Call and Lusaka PHO, Interviews at Chongwe DHO, Kanakantampa and Chalimbana RHCs																															
Team 2: Kabwe - Interviews with PMO , 3 ZISSP-seconded staff and GRZ programme officers																															
Team 1: Chongwe: Interviews with Katoba RHC staff and community volunteers																															
Team 1: Travel to Luangwa District																															
Team 2: Serenje - Interviews with DHO staff																															
Team 1: Luangwa - Interviews with Luangwa DHO Staff																															
Team 2: Serenje - Interviews with DMO, SMAGs, NHC and facility staff at Muchinka RHC																															
Team 1:Interviews with Chief Mphuka and SMAG Members																															
Team 2: Serenje - Interviews with staff at District Hospital and the Pastors' Fellowship Subgrantee																															
Team 1:Interviews withKansinsa RHC Staff and beneficiaries																															
Team 2: Travel to Mkushi																															
Team 1: Travel to Chipata																															
Team 1: Interviews with staff at the Chipata PHO staff and 4 ZISSP seconded staff																															
Team 2: Mkushi - Interviews with DMO and other DHO staff																															
Team 1: Travel to Nyimba																															
Team 2: Mkushi - Interviews with staff, NHCs and CHAs at Twatasha HP; CHA supervisor at Mansansa RHC																															
Team 1: Nyimba - Interviews with Nyimba DHO Staff, Mtilizi HP CHA, Child Fund and SMGL coordinators																															
Team 2: Interviews with DMO and other DHO staff																															
Team 1: Nyimba - Interviews with staff at Mkopela and Chipembi RHC, SMAG Members and CHAs																															
Team 2: Mopup Interviews with DHO staff and leave for followup interview with PHO Kabwe																															
Team 1: Return to Lusaka																															
Team 2: Followup interviews with seconded staff and regional representation of ZPCT II and Return to Lusaka																															
Team 1 and 2 post fieldwork meeting																															
Followup interviews and fact-finding with ZISSP, GRZ and stakeholders																															
Data analysis																															
Development of findings and conclusions																															
Systhesing and filing of field notes																															
Report Writing																															


Tasks
June
S Su M T W Th F S Su M T W Th F S Su M T W Th F S Su M T W Th F S Su
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
M T W Th F S Su M T W Th
1 2 3 4 5 6 7 8 9 10 11
Report writing. Draft sent to Mendez England for formatting
First Draft Report Submitted to USAID
Followup interviews and fact-finding with ZISSP, GRZ and stakeholders
Preparation of Debriefs and Presentations
Debrief Meetings and Presentations to USAID
Adjust presentation for ZISSP audience based on input for USAID debrief
Debrief Meetings and Presentations to ZISSP.
USAID Comments of the First Draft
Integration of Comments from USAID and debriefs in Second Draft Report
Debrief Meetings and Presentations tostakeholders
Team Leader submits draft revisions to ME&A for formatting.
Submit interview notes and materials gathered in field visits to USAID.
Second Draft Report Submitted to USAID
Debrief Meetings and Presentations
Receive Consolidated Comments on Second Draft from USAID
Integration of USAID Comments
Integration of USAID Comments. Draft to Mendez England for formatting prior to submission
Submit Final Report to USAID

ANNEX V: RESULTS FROM THE CHA SURVEY

Key Findings from the Community Health Assistant Mini-Survey

For how many months have you worked before you came to this refresher	**N**	77

training since graduation?	**Mean**	8.44

Have you received any supervision since you went back to your posting?	**N**	81
	Per cent	66.70

How many times have you been visited for supervision?	**N**	44
	Mean	3.73

What is the most recent month you were provided with supportive supervision?

Month	Number	Per cent
Aug-12	3	7.0
Sep-12	15	34.9
Oct-12	6	14.0
Nov-12	2	4.7
Jan-13	8	18.6
Feb-13	6	14.0
Mar-13	1	2.3
Apr-13	2	4.7
Total	**43**	**100**

What are the titles of other health workers besides the CHA that are there at your facility?

Title of Health Worker	Number	Per cent
Clinical Officer	3	3.7
EHT	4	4.9
Health Assistant	1	1.2
Nurse	34	42.0
No one	39	48.1
Total	**81**	**100**

Recommendations (from the CHAs) on what should be done to improve supervision

Recommendation	Number	Per cent
Supervisor require motivation	3	5.8
Need to provide transport for the supervisors	9	17.3
Supervisors need to be trained on how to supervise CHAs	14	26.9
Need for the DMOs to be properly oriented on the CHA programme	3	5.8
Supervisors to increase frequency of visits	8	15.4
Current supervisor is good	6	11.5
Current supervisor is inadequate	6	11.5
The supervisor is unavailable/not introduced/transferred/too busy	3	5.8
Total	**52**	**100.0**

ANNEX VI: PERCEPTIONS FROM THE LIKERT SCALE SURVEY

The Likert Scale Survey

Objectives of the Likert Scale Survey

The objective of the survey was to assess the perception of the leaders implementing the ZISSP interventions about the scale of attaining the objectives of the interventions. And then to assess the scale of the level of effort required to attain the objectives in the remaining period before the ZISSP programme comes to an end.

The results of the perception about the current attainment of the objectives of the ZISSP interventions, and what should be done to attain them in the remaining period of the ZISSP interventions are presented in two segments; current status of attainment and extent of effort required to attain planned targets by the end of the ZISSP programme. In these two segments, there are seven sub-groups matching the broad evaluation questions, namely;

1. Progress made towards improving access to and utilization of family planning, HIV/AIDS, malaria, MNCH and nutrition information and services in ZISSP target districts

2. Progress made to strengthen the capacity of MOH and NMCC staff at each level to plan, design, implement, manage, monitor and evaluate health programmes within the five programme areas

3. Ways in which the Ministry of Health's capacity to attract and retain health workers in rural positions improved

4. Perceptions of health workers who are currently on the Zambia Health Worker Retention Scheme about how effectively it is managed

5. Coordination and synergy of HIV/AIDS, MNCH, Family Planning and Malaria services provided by stakeholders in ZISSP target districts

6. Perception of Ministry of Health and National Malaria Control Centre regarding ZISSP seconded staff role in building the capacity of GRZ counterparts to plan, design, implement, manage, monitor and evaluate health programs at the national, provincial and district levels

7. Extent to which women have been empowered to take action in support of health behaviors and interventions in ZISSP target districts.

Scale of the Likert Survey

It ranged from 1 to 10. The 1 was for the non-existence of the programme and was not included in the analysis. The analysis was based on the scale starting from 2 to 10 providing 9 levels of the scale. Depending on the question, the strength of the perception could be towards 10 or towards 2. On most questions, it was towards 10.

Survey Sample

The questionnaire was sent to all District Community Medical Officers (DCMO) in the districts supported by ZISSP and Provincial Medical Officers (PMO) of all the provinces in the country to be answered by themselves or anyone acting on their behalf. In provinces the evaluation team went to, the questionnaire was also administered to the Specialist attached to the provincial and district health offices. The questionnaire was emailed to provinces and districts the evaluation team did not travel to. The target sample was 21 DCMO, 10 PMO and 23 specialists attached by ZISSP to the districts, provincial and national health offices of the Ministry of Health. It was also administered to health care providers found at remote health centres who are on the Zambia Health Worker Retention Scheme. These were three bringing the total sample size to 57. Most of the DCMO were also on this scheme.

Out of these 44 responded to the survey on the topics they were conversant with. There was no topic on which all the 44 responded to. The major groups that did not respond were the District Community Medical Officers in districts to which ZISSP gave support in Western Province and the ZISSP seconded staff to the Ministry of Health headquarters.

Perceptions on the Likert Scale Survey

Almost all the scores indicate an acceptable but not exceptional performance in attaining the objectives of the ZISSP up to this point. And then an equal effort is required in most areas of the ZISSP to attain the targets by the end of the programme. The lowest perceptions were on the Zambia Health Worker Retention Scheme.

The incentives on the ZHWRS were perceived to be inadequate – mean Likert score of 4.53. The scheme was perceived to be poorly managed – mean Likert score of 3.93. Empowerment of women to take action about their health was the next lowly perceived area. The extent of integrating gender in monitoring and evaluation plans was perceived at a mean Likert scale Score of 5.48. Budgeting for activities for gender integration was perceived moderately at a mean score of 6.00. There were slight differences in the mean scores between the ZISSP and non-ZISSP personnel. See Tables below.

Tables of Results for Perceptions Levels of the Current Status of Attainments by the ZISSP Program by Employee Status

Table 1: Perception about progress made towards improving access and utilisation of family planning, HIV/AIDS, malaria, MNCH and nutrition information and services in ZISSP target districts

Component of evaluation	All employees		ZISSP seconded employees*		Employees of the Ministry of Health and the Ministry of Community Development Mother and Child Health	
Progress made towards improving access to and utilization of family planning, HIV/AIDS, malaria, MNCH and nutrition information and services in ZISSP target districts	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**
Extent to which more households should be sprayed in each round of spraying in order to achieve the target coverage	23	6.35	6	8.67	17	5.53
Extent to which planning, management and stakeholder consensus for the In-Door Residual Spraying need improvement	23	5.39	6	5.17	17	5.47
Extent to which MNCH should be improved in order to attain the planned targets	33	6.70	11	7.00	21	6.52
Extent to which improvement, for example to achieve universal exclusive breastfeeding and other best infant and child feeding practices should go.	24	6.63	6	7.33	18	6.39
Extent to which reduction in child mortality should reach in order to achieve the targeted reductions	30	6.23	11	6.91	19	5.84

*Seconded to the Ministry of Health at the National Malaria Control Centre, Provincial Health Offices and District Community Health Offices of the Ministry of Community Development, Mother and Child Health

Table 2: Perception about progress made to strengthen the capacity of MOH and NMCC staff at each level to plan, design, implement, manage, monitor and evaluate health programmes within the five programme areas

Component of evaluation	All employees		ZISSP seconded employees*		Employees of the Ministry of Health and the Ministry of Community Development Mother and Child Health	
Progress made to strengthen the capacity of MOH and NMCC staff at each level to plan, design, implement, manage, monitor and evaluate health programmes within the five programme areas	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**
Extent to which more health sector personnel in your area should participate in the ZMLA in order to have enough skilled personnel in management, planning and problem identification in delivering health care services	28	7.46	11	8.36	16	6.69
Extent to which problems like stock-outs, expiration of drugs have been reduced	27	7.00	10	7.90	16	6.44
Extent to which the databases for distribution of ITNs, IRS, active case surveillance and GIS be improved to provide reliable and trusted outcomes of malaria interventions	28	7.50	10	7.60	17	7.29
Extent of work to be done to have database protocols, data quality assurance systems and universal coverage?	25	6.24	8	6.13	17	6.29
Extent to which skills, financial records, stocks records and expenditure skills be improved in order to produce National Health Accounts without external support	23	6.35	6	6.50	16	6.19

*Seconded to the Ministry of Health at the National Malaria Control Centre, Provincial Health Offices and District Community Health Offices of the Ministry of Community Development, Mother and Child Health

Table 3: Perception about ways in which the Ministry of Health's capacity to attract and retain health workers in rural positions improved

Component of evaluation	All employees		ZISSP seconded employees*		Employees of the Ministry of Health and the Ministry of Community Development Mother and Child Health	
Ways in which the Ministry of Health's capacity to attract and retain health workers in rural positions improved	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**
Extent of easing health workers requirements and accessibility to the benefits under the ZHWRS	32	5.06	7	6.00	23	4.87
Extent to which the coverage of the incentives support provided by ZISSP be increased in order to be adequate given the number of eligible health workers	32	4.53	7	5.29	23	4.26
Extent can changes in staffing in remote rural health centres be attributed to the Zambian Health Worker Retention Scheme	34	5.82	9	5.89	23	5.87
Extent to which medical supplies and equipment still need to be improved in rural health facilities	35	5.46	9	5.56	24	5.46
Extent of further improvements in livelihood conditions in order to reduce the exodus of health care personnel	35	4.89	9	6.22	24	4.54
Extent to which the salaries and overall conditions of service for health care personnel should be improved in order to retain them at their postings	32	5.72	6	7.00	24	5.21

*Seconded to the Ministry of Health at the National Malaria Control Centre, Provincial Health Offices and District Community Health Offices of the Ministry of Community Development, Mother and Child Health

Table 4: Perception health workers who are currently on the Zambia Health Worker Retention Scheme about how effectively it is managed s

Component of evaluation	All employees		ZISSP seconded employees*		Employees of the Ministry of Health and the Ministry of Community Development Mother and Child Health	
Perceptions of health workers who are currently on the Zambia Health Worker Retention Scheme about how effectively it is managed	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**
Extent ZNHWRS should be publicized so that all health workers in rural areas or those intending to work in remote areas be made aware about the compensations for hardship offered under the scheme	30	6.69	7	6.29	23	6.61
Extent to which the package of incentives should be improved?	30	5.41	7	7.14	23	4.74
Extent to which the application process should be improved	26	4.86	3	6.33	23	4.87
Extent to which the management of the scheme should be improved?	26	3.93	3	6.67	23	3.26
Extent to which health workers that are not on the scheme should be put on the scheme	25	3.22	4	4.75	21	3.14
Extent to which ZNHWRS continues to influence the stay of health workers in their current positions	23	5.40	2	5.50	21	5.43

*Seconded to the Ministry of Health at the National Malaria Control Centre, Provincial Health Offices and District Community Health Offices of the Ministry of Community Development, Mother and Child Health

Table 5: Perception about coordination and synergy of HIV/AIDS, MNCH, Nutrition; Family Planning and Malaria services provided by stakeholders in ZISSP target districts

Component of evaluation	All employees		ZISSP seconded employees*		Employees of the Ministry of Health and the Ministry of Community Development Mother and Child Health	
Coordination and synergy of HIV/AIDS, MNCH, Nutrition; Family Planning and Malaria services provided by stakeholders in ZISSP target districts	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**
Extent to which ZISSP seconded staff have contributed to the coordination and leverage of support from various cooperating partners in the health sector	39	7.28	15	7.6	23	7
Extent to which ZISSP initiatives have been peer reviewed by the Technical Working Groups and other Committees	25	6.32	8	8.13	17	5.47
Extent to which ZISSP utilises existing structures to implement activities such as In-Door Residual Spraying	33	8.00	15	8.87	17	7.18
Extent to which the programme has improved performance in achieving targets and delivering health services	31	7.13	12	7.92	19	6.63
Extent to which ZISSP indicates the areas it can support where and when	33	7.82	13	8.54	19	7.32

*Seconded to the Ministry of Health at the National Malaria Control Centre, Provincial Health Offices and District Community Health Offices of the Ministry of Community Development, Mother and Child Health

Table 6: Perception about Ministry of Health and National Malaria Control Centre regarding ZISSP seconded staff role in building the capacity of GRZ counterparts to plan, design, implement, manage, monitor and evaluate health programs at the national, provincial and district levels						
Component of evaluation	**All employees**		**ZISSP seconded employees***		**Employees of the Ministry of Health and the Ministry of Community Development Mother and Child Health**	
Perception of Ministry of Health and National Malaria Control Centre regarding ZISSP seconded staff role in building the capacity of GRZ counterparts to plan, design, implement, manage, monitor and evaluate health programs at the national, provincial and district levels	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**
Extent to which mentorship from ZISSP seconded staff has improved the skills of their mentees (counterparts)	35	7.74	12	8.33	22	7.36
Extent to which ZISSP seconded staff have contributed to the coordination and leverage of support from various cooperating partners in the health sector	37	7.41	14	8.57	22	6.59
Extent to which ZISSP seconded staff are skilled in the areas they are working.	38	8.45	15	9.27	22	7.82
Extent to which ZISSP seconded staff have supported MOH, MCD/MCH and NMCC for programme strategies, management and development of databases for monitoring and evaluation	31	7.61	13	8.15	18	7.22
Extent of implementing monitoring and evaluation strategies for activities at community level in the area of your jurisdiction	32	7.16	11	7.09	20	7.15
Extent to which ZISSP activities have improved linkages between the community based service delivery and the next level of the health care delivery	34	7.26	13	7.54	20	7

*Seconded to the Ministry of Health at the National Malaria Control Centre, Provincial Health Offices and District Community Health Offices of the Ministry of Community Development, Mother and Child Health

Table 7: Perception about extent to which women been empowered to take action in support of health behaviours and interventions in ZISSP target districts

Component of evaluation	All employees		ZISSP seconded employees*		Employees of the Ministry of Health and the Ministry of Community Development Mother and Child Health	
Extent to which women been empowered to take action in support of health behaviours and interventions in ZISSP target districts	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**
Extent to which gender roles are detrimental to the health of mothers, children, spouses and their families	31	6.90	13	7.00	17	6.76
Extent to which women's leadership of community health structures is accepted	34	6.18	12	7.25	21	5.76
Extent to which annual health plans at community, facility, district and provincial level incorporate gender issues	31	6.32	11	7.09	19	5.79
Extent to which annual budgets at community, facility, district and provincial level incorporate gender issues	30	6.00	10	6.30	19	5.74
Extent to which gender integration is monitored in the monitoring and evaluation plan	29	5.48	11	6.73	18	4.72

*Seconded to the Ministry of Health at the National Malaria Control Centre, Provincial Health Offices and District Community Health Offices of the Ministry of Community Development, Mother and Child Health

Tables of Results of Perception Levels of the Effort to Make the Current Programme Attainments in Order to Achieve the Final Programme Objectives by Employee Status

Table 8: Perception about progressto make to strengthen the capacity of MOH and NMCC staff at each level to plan, design, implement, manage, monitor and evaluate health programmes within the five programme areas

Component of evaluation	All employees		ZISSP seconded employees*		Employees of the Ministry of Health and the Ministry of Community Development Mother and Child Health	
Progress made towards improving access to and utilization of family planning, HIV/AIDS, malaria, MNCH and nutrition information and services in ZISSP target districts?	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**
Extent to which more households should be sprayed in each round of spraying in order to achieve the target coverage	23	8.30	6	9.17	17	8.00
Extent to which planning, management and stakeholder consensus for the In-Door Residual Spraying need improvement	23	6.83	6	8.17	17	6.35
Extent to which MNCH should be improved in order to attain the planned targets	33	7.82	11	7.36	21	8.19
Extent to which improvement, for example to achieve universal exclusive breastfeeding and other best infant and child feeding practices should go.	25	7.92	6	8.17	19	7.84
Extent to which reduction in child mortality should reach in order to achieve the targeted reductions	29	7.72	11	7.36	18	7.94

*Seconded to the Ministry of Health at the National Malaria Control Centre, Provincial Health Offices and District Community Health Offices of the Ministry of Community Development, Mother and Child Health

Table 9: Perception about progress to make to strengthen the capacity of MOH and NMCC staff at each level to plan, design, implement, manage, monitor and evaluate health programmes within the five programme areas

Component of evaluation	All employees		ZISSP seconded employees*		Employees of the Ministry of Health and the Ministry of Community Development Mother and Child Health	
Progress made to strengthen the capacity of MOH and NMCC staff at each level to plan, design, implement, manage, monitor and evaluate health programmes within the five programme areas	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**
Extent to which more health sector personnel in your area should participate in the ZMLA in order to have enough skilled personnel in management, planning and problem identification in delivering health care services	28	8.07	11	8.73	16	7.50
Extent to which problems like stock-outs, expiration of drugs have been reduced	25	6.92	8	7.50	16	6.69
Extent to which the databases for distribution of ITNs, IRS, active case surveillance and GIS be improved to provide reliable and trusted outcomes of malaria interventions	28	7.36	10	7.70	17	7.41
Extent of work to be done to have database protocols, data quality assurance systems and universal coverage?	25	7.24	8	7.13	17	7.29
Extent to which skills, financial records, stocks records and expenditure skills be improved in order to produce National Health Accounts without external support	23	7.00	6	7.67	16	6.75

*Seconded to the Ministry of Health at the National Malaria Control Centre, Provincial Health Offices and District Community Health Offices of the Ministry of Community Development, Mother and Child Health

Table 10: Perception about extent to ways in which the Ministry of Health's capacity to attract and retain health workers in rural positions should be improved

Component of evaluation	All employees		ZISSP seconded employees*		Employees of the Ministry of Health and the Ministry of Community Development Mother and Child Health	
Ways in which the Ministry of Health's capacity to attract and retain health workers in rural positions improved	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**
Extent of easing health workers requirements and accessibility to the benefits under the ZNHWRS	30	5.47	6	5.67	22	5.55
Extent to which the coverage of the incentives support provided by ZISSP be increased in order to be adequate given the number of eligible health workers	32	7.72	7	8.14	23	7.74
Extent can changes in staffing in remote rural health centres be attributed to the Zambian Health Worker Retention Scheme	33	6.79	8	7.00	23	6.57
Extent to which medical supplies and equipment still need to be improved in rural health facilities	36	8.44	10	8.20	24	8.50
Extent of further improvements in livelihood conditions in order to reduce the exodus of health care personnel	35	8.57	9	8.89	24	8.46
Extent to which the salaries and overall conditions of service for health care personnel should be improved in order to retain them at their postings	32	8.19	6	8.17	24	8.13

*Seconded to the Ministry of Health at the National Malaria Control Centre, Provincial Health Offices and District Community Health Offices of the Ministry of Community Development, Mother and Child Health

Table 11: Perception about extent to which the Zambia Health Worker Retention Scheme should be improved

Component of evaluation	All employees		ZISSP seconded employees*		Employees of the Ministry of Health and the Ministry of Community Development Mother and Child Health	
Perceptions of health workers who are currently on the Zambia Health Worker Retention Scheme about how effectively it is managed	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**
Extent ZNHWRS should be publicized so that all health workers in rural areas or those intending to work in remote areas be made aware about the compensations for hardship offered under the scheme	31	7.77	7	8.00	22	7.86
Extent to which the package of incentives should be improved?	32	8.44	7	8.86	23	8.52
Extent to which the application process should be improved	26	8.54	3	8.00	21	8.48
Extent to which the management of the scheme should be improved?	28	8.71	3	8.33	23	9.04
Extent to which health workers that are not on the scheme should be put on the scheme	27	5.30	4	6.50	21	5.43
Extent to which ZNHWRS continues to influence the stay of health workers in their current positions	25	7.08	2	8.00	21	6.90

*Seconded to the Ministry of Health at the National Malaria Control Centre, Provincial Health Offices and District Community Health Offices of the Ministry of Community Development, Mother and Child Health

Table 12: Perception about extent to which coordination and synergy of HIV/AIDS, MNCH, Nutrition; Family Planning and Malaria services provided by stakeholders in ZISSP target districts should be improved

Component of evaluation	All employees		ZISSP seconded employees*		Employees of the Ministry of Health and the Ministry of Community Development Mother and Child Health	
Coordination and synergy of HIV/AIDS, MNCH, Nutrition; Family Planning and Malaria services provided by stakeholders in ZISSP target districts	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**
Extent to which ZISSP personnel should improve the coordination of support to the health sector among cooperating partners	37	8.00	15	8.47	21	7.95
Extent to which ZISSP should improve its relationship with the partners in the technical working groups and other committees	25	7.88	9	8.44	16	7.56
Extent to which ZISSP supported initiatives should increase the utilization of existing structures during implementation	33	7.12	15	7.87	17	6.65
Extent to which more personnel should be included on the ZMLA programme	30	8.20	12	8.75	18	7.83
Extent to which ZISSP should improve its communication of intent and timing of support to activities in national and sub-national plans, strategies and programmes	33	7.33	13	7.38	19	7.26

*Seconded to the Ministry of Health at the National Malaria Control Centre, Provincial Health Offices and District Community Health Offices of the Ministry of Community Development, Mother and Child Health

Table 13: Perception about extent to which Ministry of Health and National Malaria Control Centre regarding ZISSP seconded staff role in building the capacity of GRZ counterparts to plan, design, implement, manage, monitor and evaluate health programmes at the national, provincial and district levels should be improved

Component of evaluation	All employees		ZISSP seconded employees*		Employees of the Ministry of Health and the Ministry of Community Development Mother and Child Health	
Perception of Ministry of Health and National Malaria Control Centre regarding ZISSP seconded staff role in building the capacity of GRZ counterparts to plan, design, implement, manage, monitor and evaluate health programmes at the national, provincial and district levels	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**
Extent to which the quality of mentorship by ZISSP seconded staff should be improved	35	7.63	13	8.08	21	7.57
Extent to which ZISSP seconded staff should improve the coordination of support to the health sector among cooperating partners	35	7.57	13	7.69	21	7.71
Extent should the skills of ZISSP seconded personnel be improved	36	6.64	14	6.64	21	6.90
Extent to which ZISSP personnel should continue offering support for programme strategies, management and development of databases for monitoring and evaluation	31	8.42	13	8.46	18	8.39
Extent of effort ZISSP should make in order to improve the monitoring and evaluation of activities at community level	34	7.94	13	7.69	20	8.25
Extent to which linkages should be improved	34	8.03	13	7.85	20	8.30

*Seconded to the Ministry of Health at the National Malaria Control Centre, Provincial Health Offices and District Community Health Offices of the Ministry of Community Development, Mother and Child Health

Table 14: Perception about extent to which women should be empowered to take action in support of health behaviours and interventions in ZISSP target districts

Component of evaluation	All employees		ZISSP seconded employees*		Employees of the Ministry of Health and the Ministry of Community Development Mother and Child Health	
Extent to which women been empowered to take action in support of health behaviours and interventions in ZISSP target districts	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**	**Sample size**	**Mean Score**
Gender stereotyping refers to the way that society expects women and men to behave and the roles they are expected to play. Have ZISSP interventions changed gender stereotyping such that women in the communities make an increasing number of decision	30	6.83	12	7.17	17	6.71
Extent to which more women should take up leadership positions in SMAGs, Radio Listening Groups, Health Centre Advisory and Neighbourhood Health Committees	33	6.76	11	8.00	21	6.05
Extent of improving gender mainstreaming in annual work plans	32	6.94	12	7.00	19	6.84
Extent of improvement in allocation of funds in the budget of your activities towards gender mainstreaming	30	5.73	10	6.30	19	5.68
Extent to which more indicators should be added to monitor integration of gender in health interventions	29	7.66	11	7.82	18	7.56

*Seconded to the Ministry of Health at the National Malaria Control Centre, Provincial Health Offices and District Community Health Offices of the Ministry of Community Development, Mother and Child Health

ANNEX VII: TRAINING ACHIEVEMENTS AGAINST TARGETS

Indicator	LOP target	LOP achievement as of March 2013	LOP achievement as of September2012	LOP achievement as of March 2012	Annual Target	January 2012-December 2012	USAID reporting year October 2011 to September 2012	SAPR results reported (October 2011 to March 2012)	October 2011 to December 2011)	Quarter 2 (January - March 2012)	Quarter 3 (April - June 2012)	Quarter 4 (July - September 2012)
r of policies, guidelines, procedures, or system changes that are identified, reviewed, adopted, institutionalized, and/or implemented with ZISSP support.												
	n/a	16	16	14	n/a		16	14	0	0	0	2
r of health care workers who successfully complete an in-service training program within the reporting period												
Mentorship	9,200	5,322	3,617	1,505	2,400	3,692	2,995	883	498	385	921	1,191
Systems Strengthening												
	2,304	1,409	663	331	980	1,026	663	331	224	107	120	212
g, PMP, MBB, HR, CHA sors)	1,813	1,766	1270	626	557	848	738	94	94	0	77	567
		1,144	855	389			533	67	67	0	52	414
		622	415	237			205	27	27	0	25	153
r of new health care workers duated from a pre-service institution within the g period	580	307	307	0	330	307	307	0	0	0	307	0
		145	145	0			145	0	0	0	145	0
		162	162	0			162	0	0	0	162	0
r of people trained in family and reproductive health with nds	900	384	313	65	200	319	270	22	22	0	99	149
Workers	360	195	172	65	80	130	129	22	22	0	43	64
		63	52	23			40	11	11	0	8	21
		132	120	42			89	11	11	0	35	43
nity	540	189	141	0	120	189	141	0	0	0	56	85
		96	68	0			68	0	0	0	25	43
		93	73	0			73	0		0	31	42
r of people trained in l/newborn health through pported programs	3,750	1,606	1209	540	1,190	1,403	1,084	415	78	337	243	426
Workers (EMoNC Providers)	340	253	233	131	120	164	177	75	33	42	82	20
		101	95	48			72	25	10	15	44	3
		152	138	83			105	50	23	27	38	17
Workers (SMAG Master s)	410	151	151	36	150	151	151	36	0	36	115	0
		58	58	11			58	11	0	11	47	0
		93	93	25			93	25	0	25	68	0
nity health volunteers **Gs)**	3,000	1,202	825	373	920	1088	756	304	45	259	46	406

Indicator	LOP target	LOP achievement as of March 2013	LOP achievement as of September2012	LOP achievement as of March 2012	Annual Target	January 2012-December 2012	USAID reporting year October 2011 to September 2012	SAPR results reported (October 2011 to March 2012)	October 2011 to December 2011)	Quarter 2 (January - March 2012)	Quarter 3 (April - June 2012)	Quarter 4 (July - September 2012)
		541	368	170			338	140	16	124	24	174
		661	457	203			418	164	29	135	22	232
r of people trained in child nd Nutrition through USG ed programs	2,148	1,800	1590	920	366	934	1,223	553	366	187	377	293
Workers	1,488	1,249	1064	597	96	731	871	404	217	187	257	**210**
		650	544	292			438	186	93	93	142	110
		599	520	305			433	218	124	94	115	100
unity	660	551	526	323	270	203	352	149	149	0	120	**83**
		267	253	151			166	64	64	0	63	39
		284	273	172			186	85	85	0	57	44
r of children who received accine by 12 months of age in istricts	2,047,000	1,302,825	1,081,175	526,645	398,000		1,081,175	526,645			512,325	0
of children who received DPT3 by 12 months of age	*74%*	*1*	*1*	*132%*	*73%*		*125%*	*132%*			*125%*	*0*
r of children under 5 years of o received Vitamin A from pported programs	12,351,000	5,002,355	3,715,299	3,715,299	2,456,000		3,715,299	3,715,299	0	0	0	
r of people trained with USG o deliver IRS	7,201	5,457	5457	4,528	915	929	929	0	0	0	59	870
ors		531	531	472	60	59	59	0	0	0	59	0
		421	421	371			50	0	0	0	50	0
		110	110	101			9	0	0	0	9	0
perators		4,926	4926	4056	855	870	870	0	0	0	0	870
		3,420	3420	2844			576	0	0	0	0	576
		1,506	1506	1212			294	0	0	0	0	294
r of houses sprayed with IRS G funds	4,953,712	2,018,631	2,018,631	2,018,631	531,791		Data not available	916,293 (86%)			Data not available	n/a
r of houses targeted for with IRS with USG funds	3,635,464	531,791	531,791	531,791	460,000		Data not available	531,791			Data not available	n/a
r of health workers trained in th USG funds	1,656	473	387	83	360	390	387	83	43	40	0	304
		162	116	34	NA	128	116	34	18	16	0	82
		311	271	49	NA		271	49	25	24	0	222
r of people trained in malaria nagement with ACTs with nds		0										

Indicator	LOP target	LOP achievement as of March 2013	LOP achievement as of September2012	LOP achievement as of March 2012	Annual Target	January 2012-December 2012	USAID reporting year October 2011 to September 2012	SAPR results reported (October 2011 to March 2012)	October 2011 to December 2011)	Quarter 2 (January - March 2012)	Quarter 3 (April - June 2012)	Quarter 4 (July - September 2012)	
unity Health Workers	1,512	815	662	262	540	542	542	142	0	142	55	345	
		630	528	201			422	95	0	95	54	273	
		185	134	61			120	47	0	47	1	72	
er of updated program manuals, clinical guidelines, protocols, or training curricula are in place and in use for specific high-impact service areas (HRH, FP, EmONC, I CHN, HIV/AIDS)													
	n/a	13	12	9	n/a		12	9			1	2	
r of people trained in C methods or materials in rget districts.	3280	1,085	535	0	450	804	535	0	0	0	274	261	
		720	364	0		538	364	0	0	0	193	171	
		365	171	0			171	0	0	0	81	90	
incidence in selected districts	97 per 1000	356	355.9		208 per 1000		355.9	355.9			3559		

ANNEX VIII: THE SUCCESS OF SAFE MOTHERHOOD ACTION GROUP IN KALOMO NAMIANGA MODEL HEALTH FACILITY OF SAVING MOTHERS GIVING LIVES ACTION GROUP TO IMPROVE THE PERCENTAGE OF WOMEN DELIVERING IN HEALTH FACILITY

UTILISATION AND QUALITY OF COMMUNITY DATA – THE CASE OF SMAG DATA IN KALOMO NAMIANGA SMGL MODEL SITE

Developing the capacities of communities is one of the strategies of the ZISSP programme to attain the objective of increasing the utilisation of health services in the programme target areas. The setting up of SMAGS is one of the ways in which the ZISSP Programme is doing this. The SMAG programme has a system of registers for tracking the success of promoting safe motherhood.

The system of registers used is not consistent in all SMAGs. Hence the different SMAGS do not record the same information although some of the information they compile in the registers is the same. The information they collect in various combinations depending on the health facility SMAGs belong to is listed below:

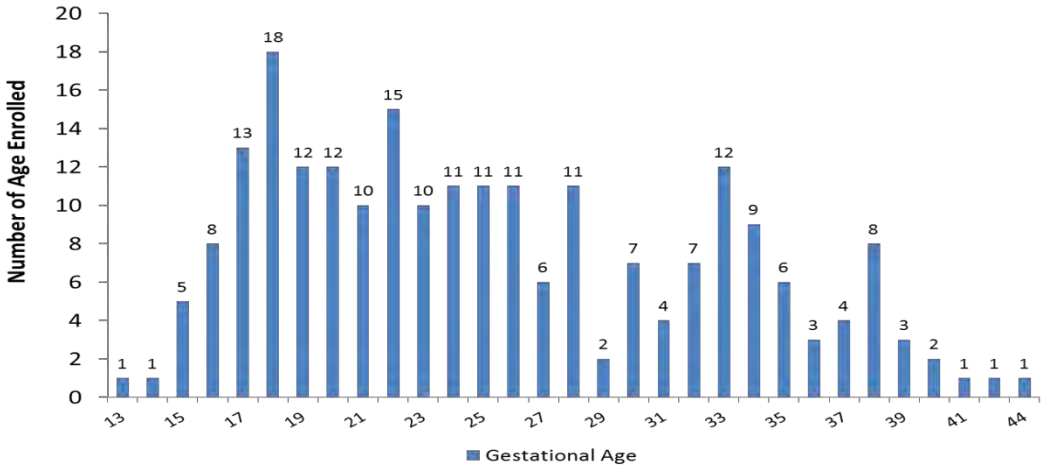
1. Name of pregnant woman
2. Address of the pregnant woman
3. Registration date by the SMAG (only recorded in the Saving Mothers Giving Lives Model-SMGL site in Kalomo Namianga SMGL Model site
4. Gestational age
5. Expected date of delivery
6. Actual date of delivery
7. Place of delivery (but only recorded in the Saving Mothers Giving Lives Model-SMGL site in Kalomo Namianga SMGL Model site.
8. Episodes of adverse events in a pregnancy
9. Frequency and dates of antenatal care
10. Pregnancy outcome
11. Outcome of the pregnancy other than birth
12. The health of the baby and mother after delivery
13. Attendance of post-natal care within six weeks after delivery

This information is pasted with pictorial banners in exercise books used to develop the registers. The SMAGS arrange this information in different orders which sometimes result in poor registers being developed.

The SMAG Register from the Kalomo SMGL Model site was used to construct a cohort of pregnant women registered in 2012 and 2013. The excel database created was analysed for coverage of the SMAGS and the progress made in attaining the SMGL focus of getting the women to deliver in the health facilities

Findings from the analysis of the Cohort data

Figure shows that there was under-coverage by the SMAGs. This would minimise the population impact of the outreach activities by the SMAGS. Despite that more pregnant women were being enrolled onto the SMAGS programme. In the cohorts followed up by the SMAGs 64.3 per cent delivered in a health facility compared to 21.7 per cent in home deliveries. There was also an increase in the percentage that delivered in health facilities from 69.5 per cent in 2012 to 78.0 in 2013.



Source: Saving Mothers Giving Lives Register at Namianga Health Facility Model Site, Kalomo

Figure 1: Age distribution of pregnant women enrolled in the Saving Mothers Giving Lives program Model Site in Kalomo Namianga Rural Health Centre Catchment Area suggestive of undercoverage by SMAGS in age 29, 31 and 33

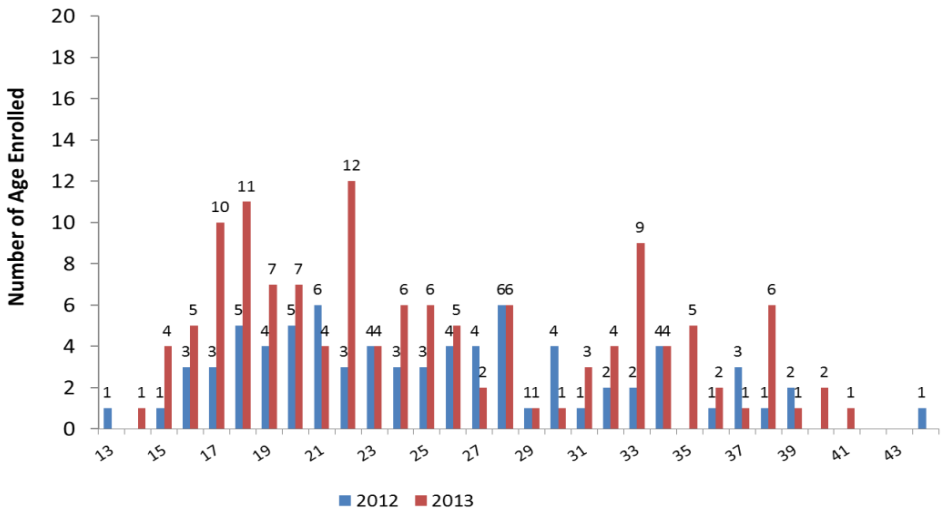
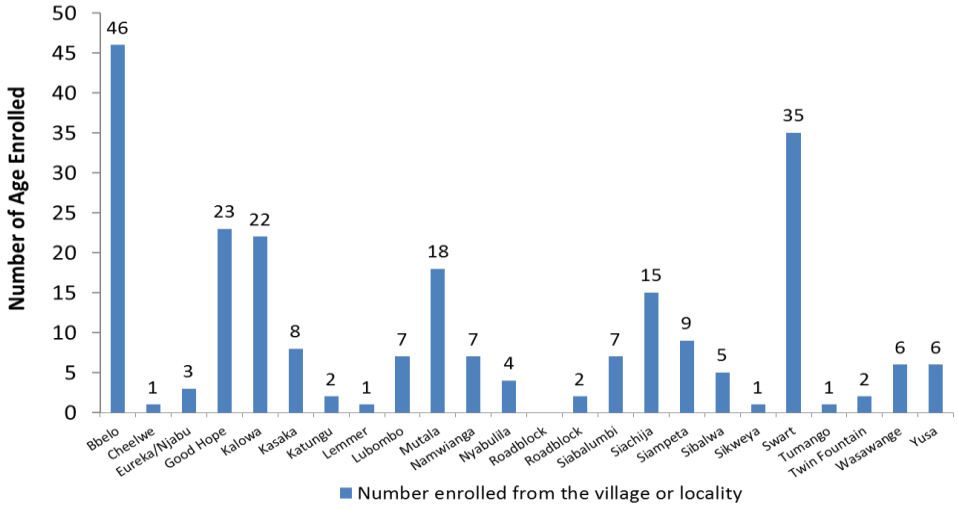


Figure 2 : Age distribution of pregnant women enrolled in the Saving Mothers Giving Lives program in Kalomo Namianga Rural Health Centre Model Site by Gestational Age and Year



Source: Saving Mothers Giving Lives Register at Namianga Health Facility Model Site, Kalomo

Figure 3: Number enrolled by SMAG Zone in the Saving Mothers Giving Lives program Model Site in Kalomo Namianga Rural Health Centre suggestive of under-enrolment by SMAG Zone

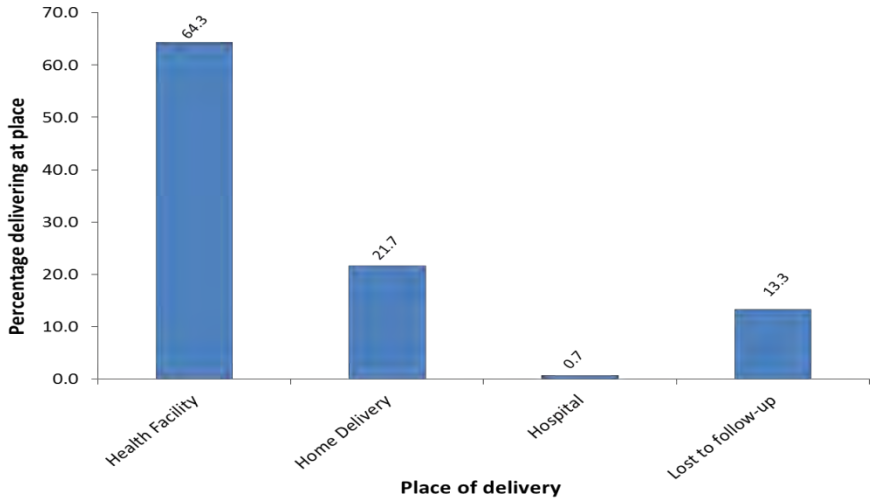
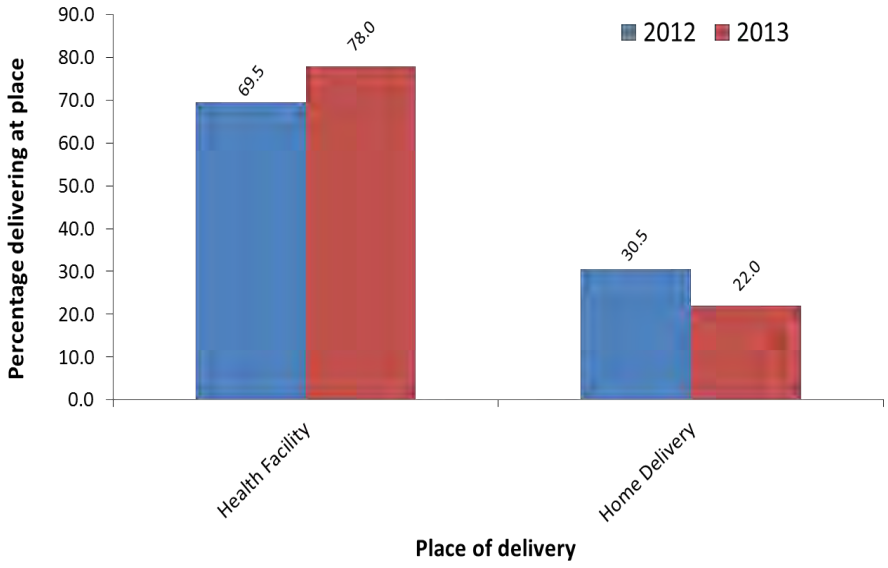


Figure 4: Percentage by place of delivery for pregnant women in the Saving Mothers Giving Lives program in Kalomo Namianga Rural Health Centre Model Site



Source: Saving Mothers Giving Lives Register at Namianga Health Facility Model Site, Kalomo

Figure 5: Increase in percentage of health facility deliveries by cohort of pregnant women in the Saving Mothers Giving Lives program in Kalomo, Namianga Rural Health Centre Model Site

Conclusions

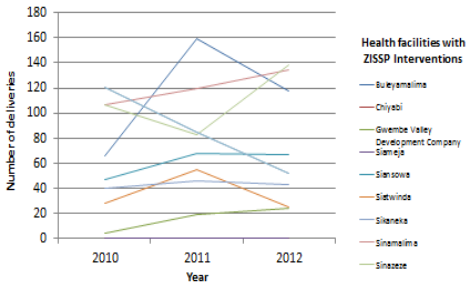
The community based data from the SMAG registers is of usable quality. Due to the long distances the volunteers have to walk or cycle coverage is not very good. Something should be done to improve the coverage by the SMAGS otherwise a lot of women and men will not benefit from the interventions being delivered by the SMAGs.

Recommendations

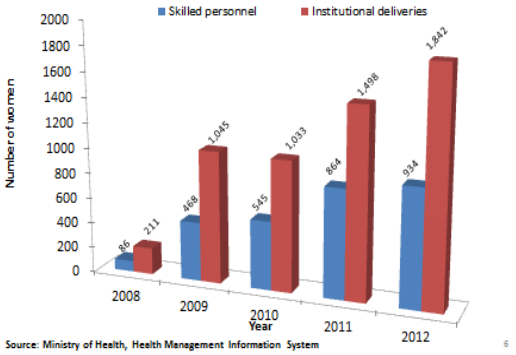
1. The SMAG registers should be standardised across all SMAGS supported by ZISPP directly or through Grantees. The best way to achieve this is to print purpose deigned registers which are not as brittle as the current ones developed from exercise books.
2. The registers should be captured into an electronic format to enable assessments for coverage and outcome of the pregnancies

ANNEX IX: GRAPHS OF INDICATORS ASSOCIATED WITH ZISSP INTERVENTIONS IN FOCUSED ANTENATAL CARE IN ZISSP INTERVENTION DISTRICTS

Number of births delivered by skilled personnel in Sinazongwe health facilities supported by ZISSP in Sinazongwe District

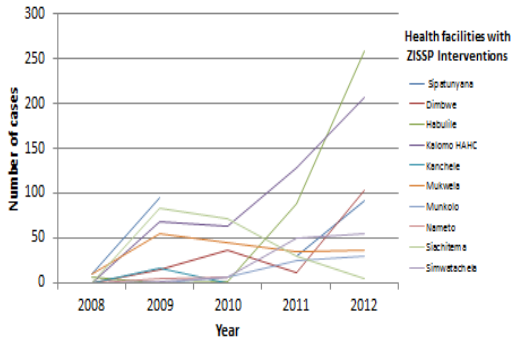


Total number of institutional deliveries and deliveries administered by skilled personnel in Lufwanyama District facilities supported by ZISSP

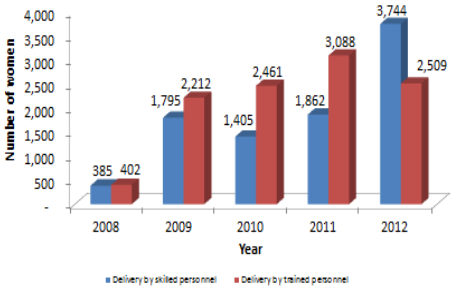


Source: Ministry of Health, Health Management Information System

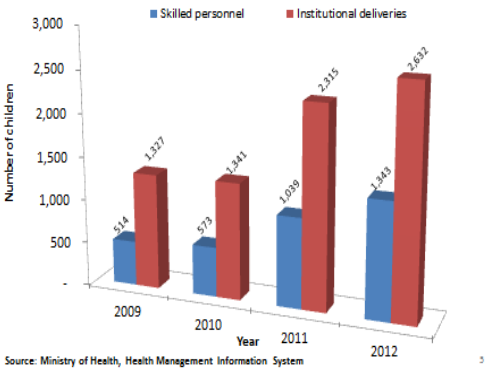
Number of births Delivered by skilled personnel in Kalomo health facilities supported by ZISSP



Number of births delivered by skilled and trained personnel in Kalomo District facilities supported by ZISSP

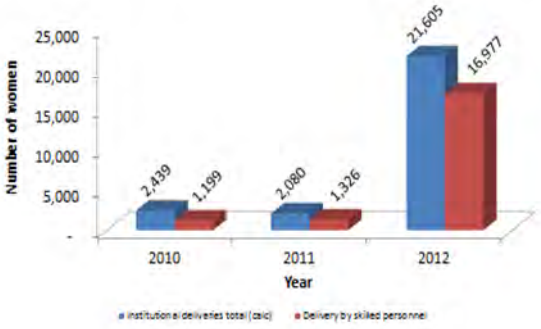


Total number of institutional deliveries and deliveries administered by skilled personnel in Nyimba District facilities supported by ZISSP

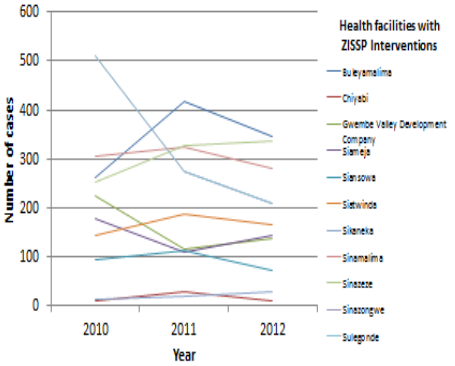


Source: Ministry of Health, Health Management Information System

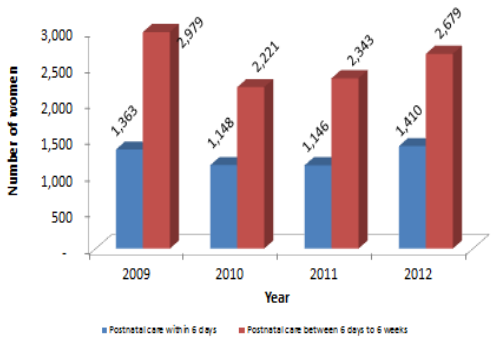
Total number of institutional deliveries and deliveries administered by skilled personnel in Mkushi District



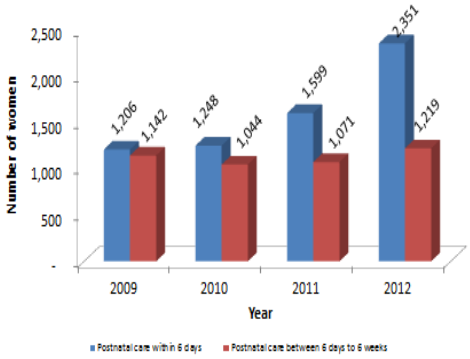
Number of mothers that received Postnatal care between 6 days to 6 weeks in Sinazongwe health facilities supported by ZISSP



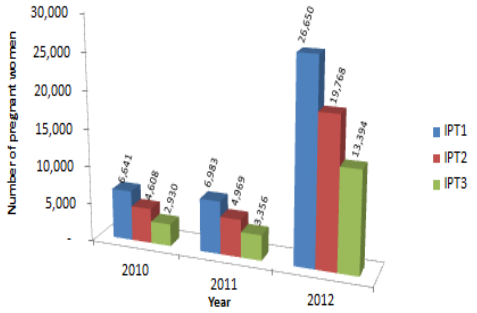
Number of mothers that received Postnatal care between 6 days to 6 weeks in Serenje health facilities supported by ZISSP



Number of mothers that received Postnatal care between 6 days to 6 weeks in Nyimba health facilities supported by ZISSP



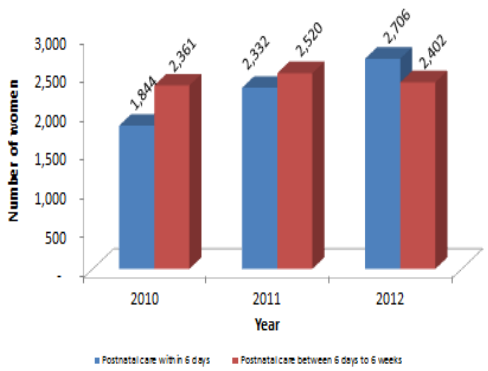
Trend in number of pregnant women that received IPT_1, IPT_2 and IPT_3 in all Mkushi District health facilities but IPT_3 still lower than IPT_2, and IPT_1



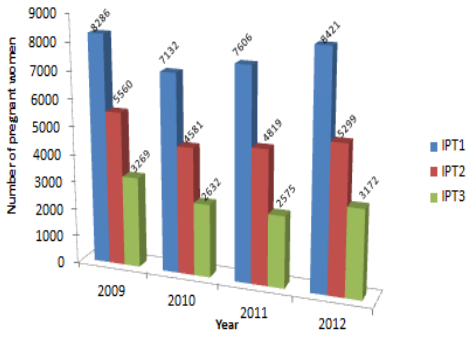
Source: Ministry of Health, Health Management Information System

38

Number of mothers that received Postnatal care between 6 days to 6 weeks in Nyimba health facilities supported by ZISSP



Trend in number of pregnant women that received IPT_1, IPT_2 and IPT_3 in all Serenje District health facilities but IPT_3 still lower than IPT_2, and IPT_1

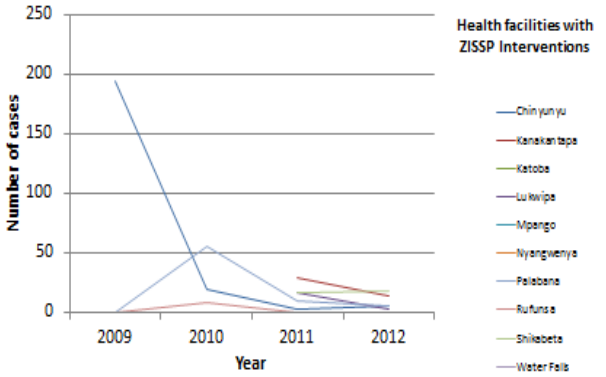


Source: Ministry of Health, Health Management Information System

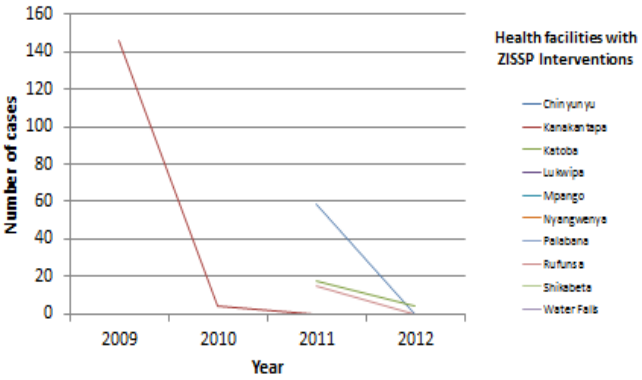
10

ANNEX X: GRAPHS OF INDICATORS ASSOCIATED WITH ZISSP INTERVENTIONS IN LONG-TERM FAMILY PLANNING METHODS IN ZISSP INTERVENTION DISTRICTS

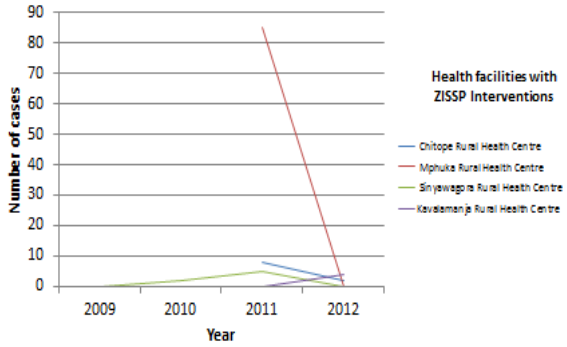
Number of women that used Implants family planning in Chongwe health facilities supported by ZISSP



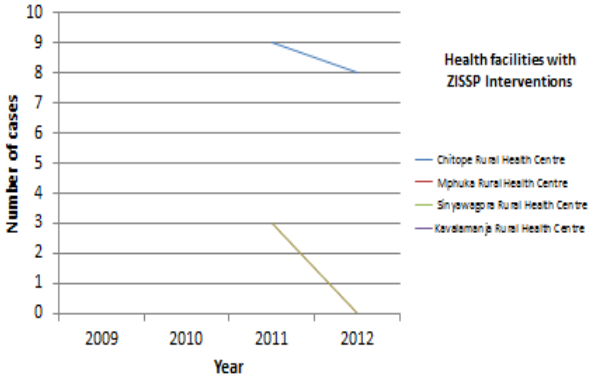
Number of women that used IUCD family planning in Chongwe health facilities supported by ZISSP



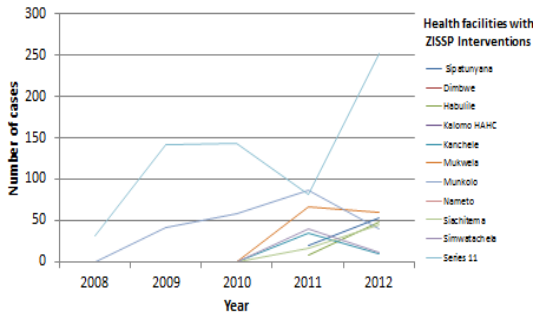
Number of women that received Implant from Luangwa health facilities supported by ZISSP



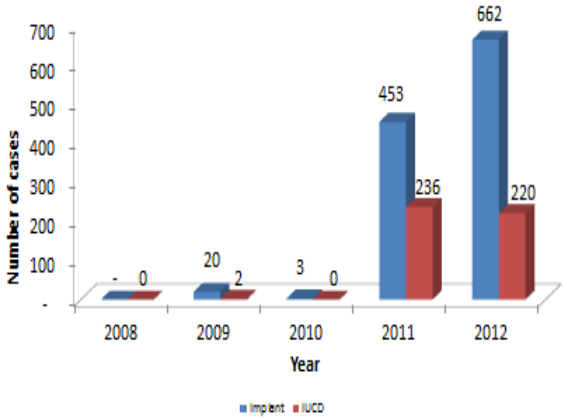
Number of women that used IUCD family planning in Luangwa health facilities supported by ZISSP



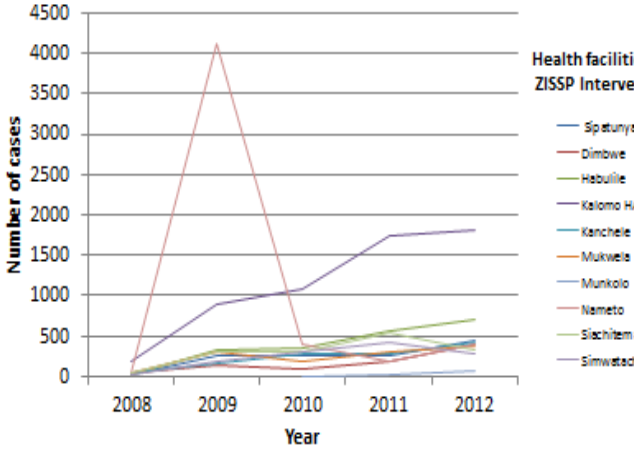
Number of women that received Implant from Kalomo facilities supported by ZISSP



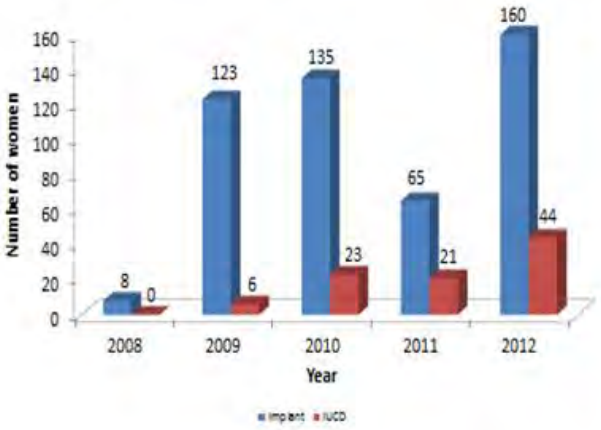
Number of women that received Implant and IUCD from Kalomo District in all facilities supported by ZISSP



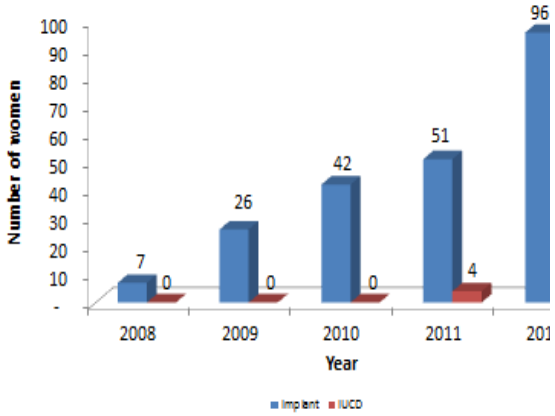
Number of women that used IUCD family planning in Kalor health facilities supported by ZISSP



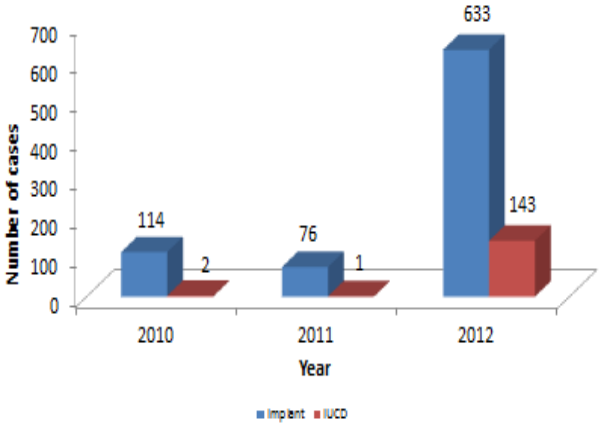
Number of women that received Implant and IUCD in Lufwanyama District in all facilities supported by ZISSP



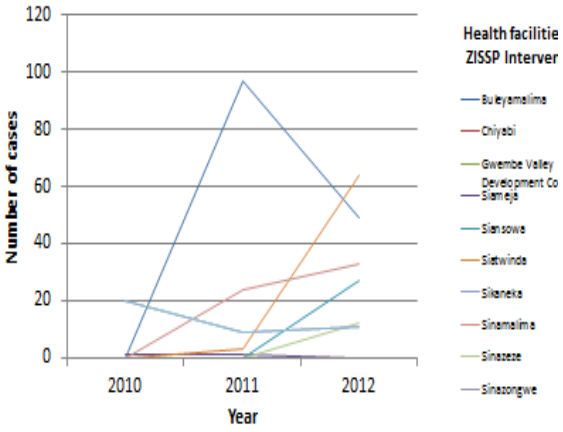
Number of women that received Implant and IU
Masaiti District in all facilities supported by ZI



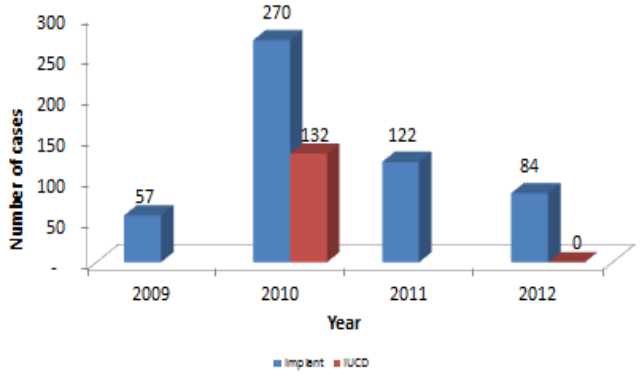
Number of women that received Implant and IUCD from Mkushi District in all facilities supported by ZISSP

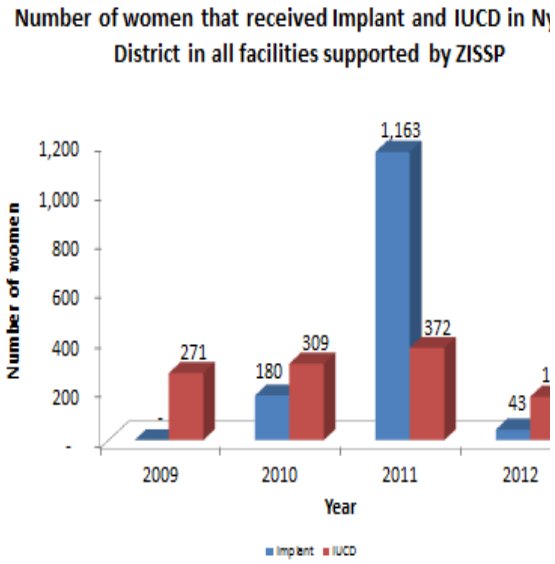


Number of women that received implant in Sinazongwe heal facilities supported by ZISSP - no headway made with cases l than 40 per year in most facilities



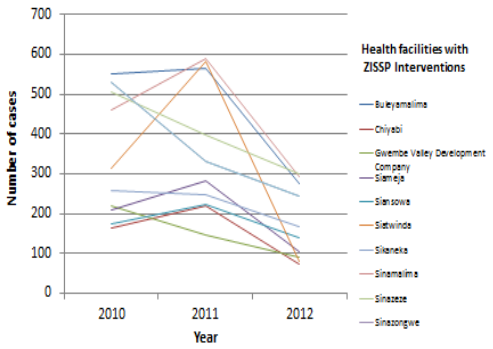
Number of women that received Implant and IUCD from Serenje District in all facilities supported by ZISSP



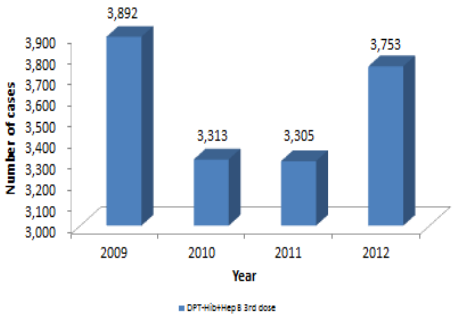

Number of women that received Implant and IUCD in N
District in all facilities supported by ZISSP
Number of women
1,200
1,000
800
600
400
200
-
271
180
309
1,163
372
43
2009
2010
2011
2012
Year
Implant
IUCD

ANNEX XI: GRAPHS OF INDICATORS ASSOCIATED WITH ZISSP INTERVENTIONS IN CHILD HEALTH AND INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS IN ZISSP INTERVENTIONS DISTRICTS

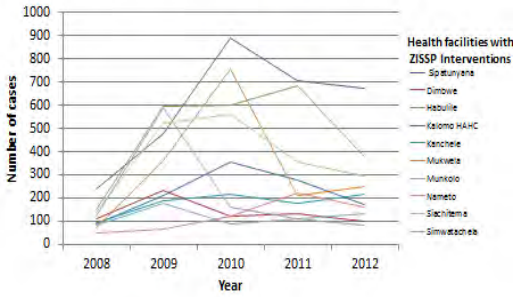
Number of children given DPT-Hib+HepB 3rd dose in Sinazongwe Health Facilities supported by ZISSP



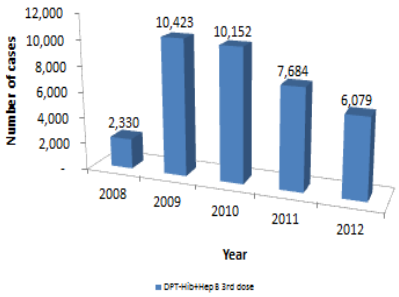
Number of children given DPT-Hib+HepB 3rd dose in Nyimba District Facilities supported by ZISSP



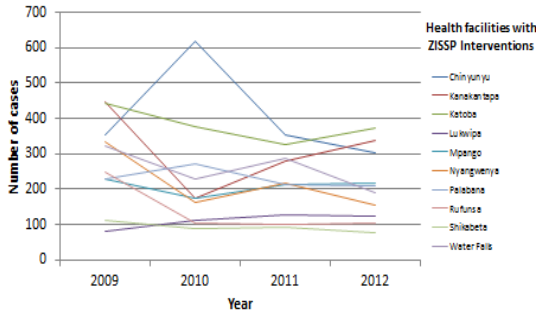
Number of children given DPT-Hib+HepB 3rd dose in Kalomo Health Facilities supported by ZISSP



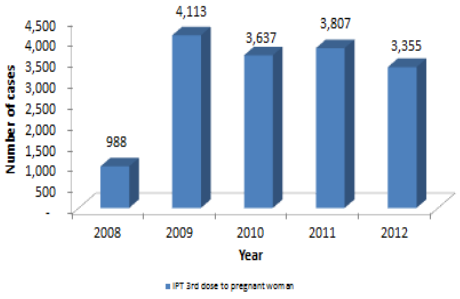
Number of children that received DPT-Hib+HepB 3rd dose in Kalomo District facilities supported by ZISSP



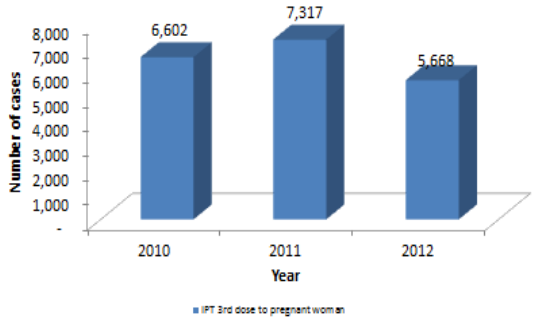
Number of children that received DPT-Hib+HepB 3rd dose in Chongwe health facilities supported by ZISSP



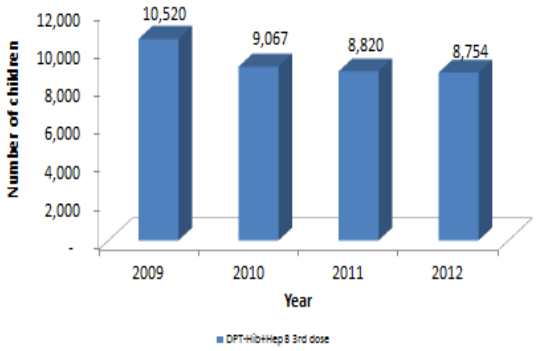
Number of children that received DPT-Hib+HepB 3rd dose in Lufwanyama District facilities supported by ZISSP



Number of children that received DPT-Hib+HepB 3rd dose Mkushi District facilities supported by ZISSP



Number of children given DPT-Hib+HepB 3rd dose in Serenje District health facilities supported by ZISSP



ANNEX XII: ZISSP PROGRAMME INTERVENTION AREAS

Province	District	Management and Leadership Training	Male Circumcision (Mentorship)	Paediatric Treatment (Mentorship)	Adult Treatment (Mentorship)	Counselling and Testing (Mentorship)	PMTCT (Mentorship)	Lab (Mentorship)	Blood Safety (Mentorship)	Other Preventions (Mentorship)	BCC	PWP (Mentorship)	Supportive Care (Mentorship)	Clinical Care (Mentorship)	Long Term Family Planning	EmONC
Central Province	Chibombo	■				■	■							■		
	Kabwe	■									■				■	■
	Kapiri-Mposhi	■			■	■	■	■		■	■			■	■	■
	Mkushi				■		■	■		■	■			■	■	
	Mumbwa		■	■	■		■							■		
	Serenje				■		■	■		■	■			■	■	■
Copperbelt	Chililabombwe			■		■	■	■						■		
	Chingola	■				■	■	■						■	■	
	Kalulushi		■			■		■		■				■		
	Kitwe	■		■	■						■			■	■	■
	Luanshya	■		■			■				■			■	■	■
	Lufwanyama			■			■	■			■			■		
	Masaiti		■	■	■			■			■			■	■	■
	Mpongwe	■					■	■						■		
	Mufulira	■		■		■	■	■					■	■	■	■
	Ndola	■						■			■				■	■
Eastern	Chadiza	■														
	Chama													■		
	Chipata	■													■	■
	Katete	■														
	Lundazi										■				■	■
	Mambwe										■				■	
	Nyimba	■	■				■				■				■	■
	Petauke	■									■					
Luapula	Chiengi										■					
	Kawambwa														■	
	Mansa	■									■				■	
	Milenge	■														
	Mwense	■														
	Nchelenge										■					
	Samfya	■														
Lusaka	Chongwe			■			■				■			■	■	
	Kafue	■		■	■		■				■	■		■		
	Luangwa	■	■	■			■							■	■	
	Lusaka	■									■				■	■

Province	District	Management and Leadership Training	Male Circumcision (Mentorship)	Paediatric Treatment (Mentorship)	Adult Treatment (Mentorship)	Counselling and Testing (Mentorship)	PMTCT (Mentorship)	Lab (Mentorship)	Blood Safety (Mentorship)	Other Preventions (Mentorship)	BCC	PWP (Mentorship)	Supportive Care (Mentorship)	Clinical Care (Mentorship)	Long Term Family Planning	EmONC
North Western	Chavuma	■				■	■							■		■
	Kabompo													■		■
	Kasempa	■							■					■	■	■
	Mufumbwe													■		
	Mwinilunga	■			■					■	■			■	■	
	Solwezi	■									■			■	■	
	Zambezi						■				■			■	■	■
Northern	**Chilubi**														■	
	Chinsali								■	■				■	■	
	Isoka													■		
	Kaputa															
	Kasama	■									■			■	■	■
	Luwingu													■		
	Mbala	■					■				■			■	■	■
	Mpika	■		■	■	■	■	■		■	■			■	■	■
	Mporokoso													■		
	Mpulungu	■												■		
	Mungwi															
	Nakonde										■				■	
Southern	Choma		■	■	■	■	■	■	■	■				■	■	■
	Gwembe		■	■	■	■	■			■	■	■		■	■	
	Itezhi-tezhi						■				■			■		■
	Kalomo	■			■	■	■	■		■	■			■	■	■
	Kazungula	■				■	■			■	■		■	■		
	Livingstone	■		■	■	■	■	■		■	■		■	■	■	■
	Mazabuka		■	■	■	■	■	■						■	■	
	Monze			■	■	■	■	■		■	■			■		
	Namwala		■				■		■	■	■			■		■
	Siavonga				■	■	■	■		■	■			■		
	Sinazongwe						■	■		■	■			■	■	■
Western	**Kalabo**	■	■	■	■		■			■	■		■	■	■	
	Kaoma	■			■		■	■		■				■		
	Lukulu		■	■	■		■	■			■		■	■	■	
	Mongu	■	■		■		■	■		■	■			■		■
	Senanga		■	■	■		■			■				■		

Province	District	Management and Leadership Training	Male Circumcision (Mentorship)	Paediatric Treatment (Mentorship)	Adult Treatment (Mentorship)	Counselling and Testing (Mentorship)	PMTCT (Mentorship)	Lab (Mentorship)	Blood Safety (Mentorship)	Other Preventions (Mentorship)	BCC	PWP (Mentorship)	Supportive Care (Mentorship)	Clinical Care (Mentorship)	Long Term Family Planning	EmONC
	Sesheke															
	Shang'ombo															

Province	District	Planning	WISN	Data Quality (Strategic Information)	Human Resource Management	Quality Improvement	CHA Supervisor	CHA Students	Geo Coding IRS	Performance Management Package	Community Infant and Young Child Feeding & Community Based Growth Monitoring and Promotion	Health Worker in Integrated Management of Childhood Illnesses	Health Workers in Infant and Young Child Feeding	Health Workers in REDs	Nutrition and HIV/AIDS	
Central	Chibombo					■				■						
	Kabwe	■	■		■	■	■			■		■				
	Kapiri-Mposhi	■				■	■			■		■				
	Mkushi					■	■			■		■				
	Mumbwa	■				■	■			■		■				
	Serenje					■	■			■	■	■	■		■	
Copperbelt	Chililabombwe			■		■								■		
	Chingola	■		■		■				■			■	■		
	Kalulushi	■		■										■		
	Kitwe	■	■	■	■					■						
	Luanshya	■		■									■	■		
	Lufwanyama			■							■		■	■	■	
	Masaiti			■									■	■		
	Mpongwe			■		■								■		
	Mufulira	■		■			■						■	■		
	Ndola	■	■	■	■	■	■			■			■			
Eastern	Chadiza	■				■	■			■		■				
	Chama					■	■			■				■		
	Chipata	■	■	■	■	■	■		■	■	■	■		■		
	Katete	■				■				■		■		■		
	Lundazi	■				■	■			■	■	■	■	■	■	
	Mambwe	■				■	■		■	■		■		■		
	Nyimba	■				■	■			■		■		■		
	Petauke	■				■								■		
Luapula	**Chiengi**			■		■	■			■			■	■	■	
	Kawambwa	■		■		■	■			■			■	■	■	
	Mansa	■	■	■		■	■			■			■	■	■	
	Milenge			■		■	■							■		
	Mwense	■				■	■			■			■	■		
	Nchelenge	■		■		■	■			■			■	■	■	
	Samfya	■		■		■	■			■				■		
Lusaka	**Chongwe**	■		■		■							■	■		

Province	District	Planning	WISN	Data Quality (Strategic Information)	Human Resource Management	Quality Improvement	CHA Supervisor	CHA Students	Geo Coding IRS	Performance Management Package	Community Infant and Young Child Feeding & Community Based Growth Monitoring and Promotion	Health Worker in Integrated Management of Childhood Illnesses	Health Workers in Infant and Young Child Feeding	Health Workers in REDs	Nutrition and HIV/AIDS	
	Kafue	■		■										■		■
	Luangwa			■			■				■	■	■	■	■	■
	Lusaka	■	■	■	■	■	■			■		■	■			
North Western	Chavuma			■		■	■								■	■
	Kabompo			■		■	■								■	■
	Kasempa			■		■	■								■	■
	Mufumbwe			■		■	■			■						
	Mwinilunga	■		■		■	■				■		■		■	■
	Solwezi	■	■	■		■	■			■	■				■	■
	Zambezi					■	■				■		■		■	■
Northern	**Chilubi**			■		■	■					■	■		■	■
	Chinsali			■			■						■			■
	Isoka			■			■						■			■
	Kaputa			■		■	■		■							■
	Kasama	■	■	■	■	■	■		■	■			■			■
	Luwingu			■		■	■		■				■		■	■
	Mbala			■		■	■			■	■	■	■		■	■
	Mpika	■		■							■		■		■	■
	Mporokoso			■		■	■		■			■	■		■	■
	Mpulungu			■		■	■			■			■			■
	Mungwi	■		■		■	■			■		■				■
	Nakonde	■		■		■	■				■	■	■		■	■
Southern	Choma			■		■										■
	Gwembe	■		■		■							■		■	■
	Itezhi-tezhi	■		■		■										■
	Kalomo	■		■		■							■		■	■
	Kazungula	■		■		■										■
	Livingstone	■		■	■	■	■			■						■
	Mazabuka	■		■		■										■
	Monze	■		■		■										■
	Namwala	■		■		■										■
	Siavonga			■		■										■

Province	District	Planning	WISN	Data Quality (Strategic Information)	Human Resource Management	Quality Improvement	CHA Supervisor	CHA Students	Geo Coding IRS	Performance Management Package	Community Infant and Young Child Feeding & Community Based Growth Monitoring and Promotion	Health Worker in Integrated Management of Childhood Illnesses	Health Workers in Infant and Young Child Feeding	Health Workers in REDs	Nutrition and HIV/AIDS	
	Sinazongwe															
Western	**Kalabo**															
	Kaoma															
	Lukulu															
	Mongu															
	Senanga															
	Sesheke															
	Shang'ombo															

ANNEX XIII: SOURCES OF INFORMATION (LIST OF ORGANIZATIONS AND PERSONS CONTACTED & LIST OF RESOURCE DOCUMENTS REVIEWED)

List of Persons and Organizations Contacted

Names	Position	Organization/Location
Banda, Crayford Kachioti	Chief Environmental Health Officer	Eastern Province PHO, Chipata
Banda, Nephat	District Planner	Kapiri Mposhi DHO
Benedictus, Mangala	Acting Planner/Planning and Budgeting	Mkushi DHO
Bornface, Chipili	Clinical Care Officer	Serenje DHO
Baumgartner, Sophie	Project Coordinator	PPAZ
Bwalya, Benson	Monitoring & Evaluation Team Leaders	ZISSP Management Team
Bwalya, Chumbo	ZISSP GIS Advisor	NMCC
Bwalya, Dr. Modern	DMO	Lwangwa DHO
Bweupe, Dr. Max	Acting Director of Public Health and Research	MoH, Headquarters, Lusaka
Chanda, Agness Kalumba	Registered Midwife, MNCH Coordinator	Luanshya DHO
Chanda, Dr. Chama	ZISSP Clinical Care Specialist	North Western PHO
Changala, Benedictus	District Planner	Mkushi DHO
Changala, Christabel	General Nurse	Kanakatampa RHC
Charles, Mwinuna	DMO	Kapiri DHO
Chembe, Elias	Registered Nurse, In-Charge	Kafulafuta GRZ RHC, Masaiti District
Chewe, Patrick	ZISSP Malaria M&E Specialist	NMCC
Chibwe, Dr. Kenneth	DMO	Kalomo DHO
Chibuwe, K.	Director of Finance & Administration	ZISSP
Chief Mpuka	Chief	Mphuka RHC
Chifuchi, Kelita	Nurse Midwife	Chalimbana RHC
Chigali, George M.	ZPCT2 Provincial Project Manager	Central Province, Kabwe
Chileshe, Humphrey	EHT – Center in-charge	Katoba Rural Health Center
Chingalike, Abraham	RH Program	UNFPA Country Office, Lusaka
Chintu, Namwinga	Executive Director	Society for Family Health, Lusaka
Chipaila, Robert	Clinical Care Specialist (ZISSP)	Northern PHO
Chipeta, Vincent	District Clinical Care Specialist	Kalomo DHO
Chisenga, Bridget Michelo.	Community Health Coordinator (ZISSP)	Lusaka PHO
Chisenga, Lackson	Community Health Assistant Supervisor	Masansa Rural Health Centre, Mkushi
Chisha, Zunda	ZISSP Active Case Surveillance Officer	NMCC
Chishimba, Shalom	Acting HR Management Officer	Mkushi DHO
Chitafu, Cosmos	Acting HR Management Officer	Luanshya DHO
Chitamya, Angela	ZISSP Management Specialist	Eastern PHO, Chipata
Chitula, Mr. Patrick	EHT – Clinic In-Charge	Kansinsa RHC
Chizonde, Agatha	Nurse Midwife	Sipatunyana RHC
Chongo, Justine	ZISSP IRS Logistics Advisor	NMCC
Chooze, Mr. Chepa	CCS – Acting DMO	Chongwe DHO
Community Volunteers	FGD	Katoba Rural Health Center

Names	Position	Organization/Location
Dabali, Florida	Enrolled Nurse, IYCF Focal Person	Fiwale Rural Health Center, Model Site, Masaiti District
Dausake, Daisy	Nurse Midwife	Chipembi RHC
Edgar, Yambagambe	Nutritionist/ IMCI Trainer	Kapiri DHO
Esther, Patricia, Rose	3 other CHAs in district	Mkopeka RHC
Fortune, Masiya	Enrolled Nurse Midwife	Namwianga Zonal RHC
Fumbeshi, Henry M.	Principal Planner	Kabwe PHO
Fwambo, Daniel	Capacity Building Specialist	ZISSP Management Team
Gandhi, Meena	Health Advisor	Department for International Development (DFID)
Habasimbi, Dr. Brian	Medical Doctor	Gwembe DHO
Hachundwe	Environment Health Technician	Kafulafuta Block HC, Luanshya
Clarence, Hamalala	Information Officer	Sinazongwe DHO
Hampango, Chimuka	JSI Provincial Public Health Logistics Advisor	Central PHO, Kabwe
Hachimena, Joseph	PMO Health Promotion Officer	Central PHO, Kabwe
Hanyinga, Exhilda Kasumu	Nurse Midwife	Kansinsa RHC
Hasowela, Manual	District Nutritionist	Serenge District Medical Office
Hazemba, Grace S.	Principal Nutritionist	Copperbelt Province, PHO
Inambao, Eric	DHO	DMO, Serenje
Jaliso, Ivo	Public Health Officer/Malaria Focal Person	Mkushi DHO
Jesper, Musonda	Acting DMO	DHO, Masaiti
Juunza, Esnart	SMGL District Cooordinator	Kalomo DHO
Kabalo, Dr. A.N.	PMO	PHO, Kabwe
Kachemba, Arthur	Monitoring & Evaluation Officer	BRITE
Kadantu, Mable Chongo	Senior Midwifery Tutor	Roan Antelope Hospital DEM School, Luanshya District
Kafula, Besa	Acting CCS	Nyimba DHO
Kafunga, Jestina	District MCH Coordinator	Gwembe DHO
Kaimba, Henry	Director of Programs	PPAZ
Kalangu, Givas	Communication for Development Officer	UNICEF Zambia
Kaluba, Musonda	Management Specialist (ZISSP)	PHO, Ndola
Kamenda, Edith	District Nursing Officer	Sinagongwe DHO
Kamuliwo, M	Deputy Director	NMCC/MOH
Kangala, Golden	HR Management Officer	Masaiti DHO
Kanweka, William	ZISSP COR	USAID Zambia
Kapembwa, Dr. K.	ZISSP Clinical Care Specialist	PHO, Kabwe
Kapemfu, Kingsley	Acting Senior Health Information Officer	PHO, Ndola
Kasoma, Emily	Human Resources for Health Program Manager	CHAI
Kasawa, Bernard	ZISSP Community Health Team Leader	Lusaka PHO
Kaseka, Pastor	Project Financial Controller	Serenge Pastor's Fellowship
Kashumba, Saxon	Environment Health Technician	Muchinka Rural HC, Serenje

Names	Position	Organization/Location
Kasonga, Benjamin	Accounting Officer	Masaiti DHO
Katongo, Nathan	MCH Coordinator	Mkushi DHO
Kaumba, Misheck	Nurse Midwife, In-Charge	Fiwale Rural Health Center, Model Site, Masaiti District
Kinsgely, Kapemfu	District Health Information Officer	Luanshya DHO
Kumar, Ritu	DCD	CHAI
Kunyi, Jonathan	SMGL Coordinator	Nyimba DHO
Lambo, Nilda	Chief, Health, Nutrition and HIV/AIDS	UNICEF, Lusaka
Langa	Planner	Luanshya DHO
Lepper, Mnsonda	Acting DMO	Masaiti District
Liwewe, T.	Enrolled Midwife	Kafulafuta Block HC, Luanshya
Luhuna, Constance	Clinical Officer	Serenge District Hospital
Lungu, Ken	Data Associate (CHAZ)	Fiwale Health Centre
Lusumpa, Rebecca	ZISSP SMGL Provincial Coordinator	Eastern PHO, Chipata
MacGrey, Mulendema	Midwife/DEM Clinical Instructor	Roan Antelope Hospital DEM School, Luanshya District
Makusa, Dayton	ZISSP IRS Advisor	NMCC
Malakata, Dr. Oscar	ZISSP Provincial Clinical Care Specialist	Copperbelt PHO
Malakata, Oscar	Clinical Care Specialist (ZISSP)	Copperbelt PHO
Malama, Dr. Kenneth	PMO	Chipata PHO
Malwanda, Felix	Health Promotion Officer	Gwembe DHO
Mano, Payne	Programme Manager	COIHEP, Luanshya
Mangala, B.	Acting Planner, Budgeting and Finance	Mkushi District DHO
Mapulanga, Dr. Pule	Clinical Care Specialist (ZISSP)	Eastern PHO, Chipata
Marx, Melissa	Chief, Surveillance, Epidemiology, Eval. & Monitoring Branch	Centers for Disease Control and Prevention (CDC) American Embassy, Lusaka
Masenga, Ernest	Community Health Assistant	Twatasha Rural Health Post, Mkushi
Masheke, Kaunda	In-charge	Fiwale Health Centre, Masaiti
Mashonga, Dennis M.	Pastor's Fellowship Zonal Coordinator	Muchinka RHC Catchment, Serenje
Masuwa, Florence M.	Hospital Pharmacist	Serenge DHO
Matoka, Francis	Malaria Focal Person	Masaiti District
Mawza, Precious	Nurse Midwife/SMAG Trainer	Luanshya DHO
Maswenywlu, S.	HIV/AIDS (PMTCT) Specialist	UNICEF Zambia
Mayumshi, Loveness	MCH Coordinator	Serenge DHO
Mbesha, Juliet	ZISSP Grants Manager	ZISSP – Management Team
Mbewe, Vera	Community Health/BCC	ZISSP Management Team
Menke, Jack	Technical Director	EGPAF, Lusaka
Mfumbila, Rachael	Community Health Assistant	Twatasha Rural Health Post, Mkushi
Mfume	Principal Planner	Central PHO
Mfune, Tiza	DMO	Serenje DHO
Miti, Jean	District SMAG Trainer	Chongwe DHO

Names	Position	Organization/Location
Mlewa, Andrew	Deputy Chief of Party/Director of Programs	ZPCT II
Monga, Jane	Pharmacist	Kapiri Mposhi DHO
Moonze, Emily	Management Specialist Team Leader (ZISSP)	ZISSP Management Team,
Morita, T.	Enrolled Nurse/LTFP provider	OPD Serenje District Hospital
Mpankani, Edith	Nursing Officer, Nursing Care and Standards	Kapiri DHO
Mpharo, Kingston	Enrolled Nurse	Kafulafuta Block HC, Luanshya
Mpsokota, S.	Senior Health Education Officer	Central PHO Kabwe
Mr. Mshanga	HR Director	MoH Headquarters, Lusaka
Msimuko, Rachel	Pharmacist	Mkushi DHO
Mtonga, Euphrasia	ZISSP Community Health Coordinator	Central PHO Kabwe
Mtonga, Pastor Kervin Z.	Project Manager	Serenge Pastor's Fellowship
Muchengwa, Terence	ZISSP Management Specialist	Central PHO Kabwe
Mufune, Dr. Tiza	DMO	Serenge DHO
Mugala, Nanthalile	ZISSP Director Technical Services	ZISSP Management Team
Mukelabai	Enrolled Nurse	Kafulafuta Block HC, Luanshya
Mukelabai, Maureen	Management Specialist (ZISSP)	ZISSP Management Team
Mukendi, Roman	Programme Officer	BRITE
Mulendema, David	Planner	Ndola PHO
Mulenga, Cecilia	Nurse Midwife/IYCF supervisor	St. Joseph's RHC Lufwanyama District
Mulenga, Idali C	IYCF Coordinator	NFNC
Mulenga, Dr. Peter	DMO	Luanshya DHO
Mulenga, Nampolele	Principal Nutritionist/ IYCN Master Trainer	Central PHO
Mulunda, Mukata	ZISSP Community Health Coordinator	Eastern PHO, Chipata
Mulwani, Brian	Accountant	Mumuni Center -Grantee
Munsaka, Ian	Dental Therapist	Namwianga Zonal RHC
Musapa, Mukunga	ZISSP Entomologist	NMCC
Musokotwane, Dr.	Acting DMO	Southern Province – Choma PHO
Musonda, Charity	Facility In-charge	Kafulafuta Block HC, Luanshya
Musonda, Dr. Bweupe	Medical Doctor	Gwembe DHO
Musonda, Dr. Siyalwe	Acting DMO Rufusa – New district.	Chongwe DHO
Musonda, V.	Administrative Officer	Central PHO Kabwe
Musonda, Victoria	Clinical Care & Quality Improvement Team Leader	ZISSP Management Team
Musumali, Masuka	FP/MNCH Advisor	USAID Zambia
Mutembo, Dr. Simon	Clinical Care Specialist	Southern Province – Choma Provincial Health Office
Muteteka, Joseph	Prov. Nursing Officer	Chipata Provincial Health Office
Muzia, Lucy	ZISSP Insectary Technician	NMCC
Mwambepa, Asumi	Medical Licentiate	Serenge District Hospital

Names	Position	Organization/Location
Stephen		
Mwangala, Evans	Acting District Health Information Officer	Kapiri Mposhi DHO
Mwansa, Patrick	Monitoring & Evaluation Manager	ZISSP Management Team
Mwanza, Dr. Rosemary R.	DMO	Mkushi DHO
Mwanza, Elias	Mtilizi Health Post CHA	Nyimba DHO
Mwanza, Julius	CO – Clinic In-charge	Sipatunyana RHC
Mwanza, Mpundu	Community Health/BCC	ZISSP
Mwelwa, Chaswe	Principal Nursing Officer/MNCH Coordinator	Copperbelt Province PHO
Mwanza, Rosemary	DMo	Mkushi District DHO
Mwinda, Dr. Oscar	DMO	Gwembe DHO
Mwinuna, C	DMO	Kapiri District DHO
N/A	MNCH Coordinator	Masaiti DHO
N/A	Medical Officer	St Joseph Health Centre, Lufwanyama
N/A	Enrolled Nurse	Mibenge Rural Health Post, Lufwanyama
Mtonga, Kervin	Project Director, Serenje Pastor's Fellowship	Subgrantee -Pastors Fellowship, Serenje
Kaseka, John	Project Financial Controller, Serenje Pastor's Fellowship	Subgrantee -Pastors Fellowship, Serenje
N/A	District Medical Officer	Kapiri Mposhi DHO
Nakawala, G.	Management Specialist (ZISSP)	Lusaka PHO
Nalavwe, Evelyn	Acting Programme Manager	COIHEP, Luanshya
Nalishebo	Senior Accountant	Ndola PHO
Nampolele, Mulenga	Principal Nutritionist	Central PHO Kabwe
Ndhlovu, Victoria Nkhomeshya	District MCH Coordinator	Lwangwa DHO
Nebert, Mwanza	Acting DMO	Lufwanyama DHO
Neroh, Dr. Chilembo	DMO	Sinagongwe DHO
Ng'ambi, Dr. Chandwa	PMO	Copperbelt PHO
Ngongo, Dr. Amisi	In Charge and Focal Person for QI	St. Joseph's RHC Lufwanyama District (Model Health Center)
Njekile, Wendy	ZISSP Community Health Coordinator	Copperbelt PHO
Nkausu, Joseph	Program Manager	Mumuni Center -Grantee
Nkhata, Alex	Zambia Enrolled Midwife	Muchinka Rural HC, Serenje
No names	2 pregnant ANC patients and 2 new mothers	Kansinsa RHC
Nondo, Edward	Management Specialist (ZISSP)	North-western PHO
Nsakanya, Richard	Senior Advisor, Capacity Building	ZPCT II, Lusaka
Nyekele, Wendy	ZISSP Provincial Community Health Coordinator	Copperbelt PHO
Nyendwa, Patrick M.K.	ZISSP Community Health Coordinator	North-Western PHO

Names	Position	Organization/Location
Nyirenda, Wezi	Provincial Laboratory Officer	Eastern PHO Chipata
Patel, Sangita	Health Team Leader	USAID Zambia
Paxina	unknown	Gwembe DHO
Phiri, Caroline	MCDMCH Director of MCH	GRZ MCDMCH
Phiri, Tony	IT Specialist	Ndola PHO
Poer, Kathleen	ZISSP Chief of Party	ZISSP Management Team
Roberts, Melinda	CSH COR	USAID Zambia
Sakala	District Planner	Kalomo DHO
Sakala, Paul	Child Fund District MCH Coordinator	Nyimba DHO
Sankondo, Crispin	Clinical Care Officer	Masaiti DHO
Sekeleti, Darison	CO – Clinic In-charge	Namwianga Zonal RHC
Shimbini, Gibson	Health Education Specialist	Serenje DHO
Siachoono, M.	Public Health Nurse/SMAG Trainer	Central PHO Kabwe
Sichamba, Annie	MCH Coordinator	Lufwanyama DiHO
Siloandwa, G.	Data Management Specialist	Central PHO Kabwe
Silweya, Timothy	Community Health Coordinator (ZISSP)	Luapula PHO
Simfukwe, J.K.	Senior Accountant	Central PHO Kabwe
Simpungwe, Gamariel	Deputy Director Malaria, Family Planning, Essential Medicines and Training	John Snow, Inc. Lusaka
Simukanzye, Eridge	ZISSP Community Health Coordinator	Southern PHO Choma
Simuunza, Passwell Mudenda	Clinical Care Officer	Kapiri DHO
Bernard, Simuwelu	CCS	Sinagongwe DHO
Sinkala, Mike	Health promotion Focal Person	Nyimba DHO
Sinyenge, Dr.	DMO	Nyimba DHO
Sinyinza, Elijah	ZISSP Deputy Chief of Party	ZISSP Management Team
Sinyiza, Christopher	Management Specialist (ZISSP)	Luapula PHO
SMAG members	FGD	Sipatunyana RHC
SMAG Members	FGD	Mphuka RHC
SMAG Members	FGD	Mkopeka RHC
SMAG Members	FGD	Chipembi RHC
SMAG Members under sub-grantee	FGD	Luyaba RHC
Sooka, C.	Provincial Nursing Officer	Central PHO Kabwe
Spranka, Mark	VP, Reputational Capital and Technical Leadership	Abt Associates, Cambridge, Mass.
Tembo, Alfred	ZISSP Management Specialist	Northern PHO Muchinga
Tembo, Eliot	Acting Public Health Officer	Nyimba DHO
Tembo, Susan	HIV/AIDS Advisor	WHO
Terrence, Muchengwa	Management Specialist (ZISSP)	Central PHO
Valasquez, J.	Reproductive Health Spec/SMGL focal person	USAID Zambia
Waitolo, Nelsen	Public Health Officer	Lufwanyama DHO
Wakefield, Christina	Technical Director	Communications Support for Health

Names	Position	Organization/Location
Wallon, Michelle	Director	MCHIP
Wamulume, Dr. Chibesa S.	Malaria Clinical Case Management Officer, also Acting for NMCC Director	NMCC
Welsh, Michael	Country Director/COP	ZPCT II
Wina, Hilda	ZISSP Seconded Staff to MCDMCH FP	ZISSP/MCDMCH
Zimba	Acting District Health Information Officer	Luanshya DHO
Ztamgo, Rosemary	Midwife/DEM Clinical Instructor	Roan Antelope Hospital DEM School, Luanshya District
Zulu, B.	EHT, IMCI supervisor	Fiwale Rural Health Center, Model Site, Masaiti District
Zyongwe, Nancy	ZISSP Clinical Care Specialist	Southern PHO Choma

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ANNEX XIV: SUMMARY OF REPORTS FROM GROUP MEETINGS AND WORKSHOPS

National Level Interviews

1st Meeting with ZISSP Sr. Management Team
Monday 8 April

Kathleen Poor, COfP; Dr. Elijah Sinyinza, Dep COP, Kasubika Chibuye, Dir of F&A; Nanthalile Mugala, Director of Tech Support

Introductions, request for organogram, seconded staff contact list, and list of grantees,

Overview slide presentation, also have presentations on each program area. Programs for support at central level, etc.

Project duration 7/10 to 12/14

Contract not CA, cost plus fixed fee contract, base funding is $88 million

Expenditures $47,524 to date.

Abt prime, Akros Research malaria, ACNM EmONC and MNCH , BRITE management and leadership training, JHU CCP HE and BCC, Liverpool School of Tropical Medicine malaria, research methodology and M&E/entomology, PPAZ FP/RH

2 local entities: BRITE has registered as local and PPAZ.

In original design Banyan Global their original focus was on public/private partnerships; USAID already had a project CHAMP that had established partnerships for Global Development Alliance, private partners not interested in other arrangements with Banyan. USAID was disillusioned by GDA process.

They started and succeeded but took 18 months to get a GDA agreement in place. No contract amendment to drop them out.

Counterparts: MOH and MOCDMCH, Central ministry depts., NMCC, TWG, provincial and District MOs facility managers, CHWs, HCACs, NHCs, SMAGs

Related USG programs: ZPCT2 – HIV in northern half of country; Center for Infectious Disease Research in Zambia CIDRZ; Private Sector Social Marketing PRISM; CSH; JSI/SCMS and Deliver, SMGL multiple implementing partners – endeavour not project under GHI, Zambia and Uganda are 2 pilot countries. Jorge at USAID and Dr. Jim McCully CDC. USAID had no incremental funding, but CDC did gave in EP to CIDRZ and SP to BU. So able to implement new interventions, whereas USAID partners looking for opportunities to tuck this into existing scope of work, so concentrated more resources in core districts than otherwise would have, initial plan to form SMAGS and training in EmONC (?), ZISSP supplied districts with district coordinators to help various partners coordinate SMGL activities. The 50% goal was set in Dept. of State.

Meeting next week in Livingston where all partners for SMGL coming together. Too many people invited already. Both Uganda and Zambia are presenting, rolling out to new countries. Malawi is a new country. Next Tuesday is all partner day for SMGL in Livingstone.

Four ZISSP tasks: nice diagram to show levels: national Task 1, Province and District Task 2 many resources here, Community Task 3 much of this work is through the district rather than directly. 4th task: build systems and capacity and leverage resources and engage partners – integration and CB –

Have not exercised Option 5 regarding food/nutrition. Feed the Future funds for Zambia have been problematic because of macro issues, no national plan, etc. FF money has been slow overall.

USAID asked for HSS, but also asked for systems support including seconded staff and training, MOH asked USAID for personnel, MOH priorities are heavily focused on support for basic services.

Role of seconded staff is very challenging; in many places they are doing GRZ's job.

Rubrics cube diagram for WHO HSS building blocks

In some areas where we work we do have a Systems Strengthening contribution but not in all; our role really is to support MOH in program areas and in provincial health offices.

CDC is funding programs to strengthen nursing training; they fund CIDRZ local NGO formed with CDC support, became lead organization and subcontracts to UNC for TS, have reversed roles.

When you read the contract, there is a lot about basic things like training, then we've tried to increase the trainer pool a more systems level intervention, help with curriculum revision, make training more efficient. Adding an SS dimension to basic activities.

SMGL 50% reduction "aspirational goal". This was foisted on the mission and on ZISSP. Was it formally added to contract? If not, what responsibility does ZISSP have to meet goals?

Context: project reaches across the whole country; project also covers multiple program areas, project also seeks to address all levels of the health system: central ministries, provinces, districts, facilities, communities. Some places where we're working may be a full day drive. Time for travel is significant.

Request for information on the facilities and communities where ZISSP focuses. Yes, we selected focus facilities and their associated communities, will provide that.

27 target districts, new districts are forming, some provinces are being divided. Usually when a new district or province is being 'sliced off', the ministry sees it as a parent and child relationship so ministry and ZISSP's role is to continue to support both.

Work in communities is focused mostly on Task 3 activities. We tried to focus more to a smaller group of 10 districts, so one key district per province. How were districts selected? ZISSP made proposal, vetted by? TWG, thought about how it would impact other programs, balanced among provinces, NP had 12 districts, so chose 4, Lusaka had only 4 districts, so allotted 2, others got 3. Equity was principle. 4 criteria: ranking of district on League table, simple metric used by M with 10 key indicators to compare districts; a ranking system to show availability of HR in relationship to establishment list, desired staffing and sufficiency; presence of other partners; and one more.

Were any former HSSP districts? Selection bias was to get the worst, lowest rank on League table and with fewest partners but with sufficient HR so possible to do CB. At same time WB was planning a RB financing program and had selected 18 intervention districts and 9 control districts. Some part of HC financing working group wanted no overlap between WB and ZISSP districts, making selection difficult. In end ZISSP ended up overlapping evenly with WB in terms of locations of the RBP 2 groups (2 types of packages in WB project, one with more robust funding) and the control group. In WP PHO insisted on certain districts.

Request for target district selection report. Given that districts are lowest performing in many cases they are also hardest to get to. In new province, Muchinga, government gave them a district that doesn't have a connecting road.

More context – health system:

High levels of Maternal and Child M and M, malaria, high fertility rate, high stunting rate.

Highly centralized personnel systems for all government (recruitment happens through cabinet office).

HR information systems also highly centralized.

Insufficient production and uneven distribution of HR to meet management and facility needs.

Rural areas often thinly populated.

Retention of trained staff is a challenge.

Personnel transfers are frequent and not always well coordinated (central management systems); people may go to training programs that their own DMO may not know about it. Problematic communication channels, not all flows through normal hierarchy. Challenging for this projects with its big emphasis on CB.

More about this in the HRH discussion. ZISSP is doing an assessment now about how well the retention strategy is working. ZISSP is a contributor to the pool, reimburses MOH for portion of people who are on the scheme. Way to transfer resources as a reimbursement, funds go to MOH rather than flowing through M o Finance.

New MCD/MCH. Got a new mandate with new government, which is MCH.

New provinces (1) and districts (20 plus).

In 2009 donors suspended contributions to basket funding mechanism. Caused a contraction in financial resources for health, especially at district level. In last ¾ months, government and donors signed a framework to create a foundation that will enable donors to begin to contribute again. Due to a GF audit that found many concerns.

G to G mission is here, led by Deloitte, trying to figure out how to do direct government funding. UNDP is proxy prime recipient on behalf of MOH for HIV grants, malaria, TB.

ZISSP does no HIV/TB programming. USAID's TB investment is through other IPs.

Big function of this work is to strengthen planning processes, but one of the challenges is that districts have maybe ½ to 1/3 of prior funding because of cessation of basket funding.

Work to support and strengthen systems for planning, implementation, monitoring – districts plan based on indicative budget figure, then population grows but budget shrinks and/or flow of funds is not reliable. Don't receive regular and even tranches. K: in last 2 years, financial reports show nearly 100% funding in budgets, that government is better keeping its commitments. But districts will say our grant didn't come for 2 months, just now receiving it. K: you see the yellow books, Form C. What is allocated is being actually committed. But it sounds as if they are not getting funds in timely way. They may get nothing in two quarters, and then funds for all three quarters at a time.

Context: Capacity Building

Big needs for in service training to address new and evolving programs while pre service curriculum revisions lag and also for providers already in sector. HIV hasn't been fully integrated into pre service curricula yet. Do medical universities play any role in in service training? WB made agreement with a provider organization as a training resource for their RB financing program. Some universities do train nurses?

Worker mobility and attrition

Highly centralized system to approve training – PS signs off on every training invitation letter.

Trainers are often also employed at the central Ministry level – insufficient number of PHO led trainers in many areas.

Trainers are MOH or MCH staff members who have many other responsibilities – constant tension between their role as trainers and other job responsibilities. A mixed blessing is that project is working with pool of trainers who are MOH staff with demonstrated technical competence who become part of the pool of national trainers. But there is no JD that says they are only trainers; they have other duties as well, so hard for ZISSP to find trainers who are available to assist with scheduled trainings. Not enough HR to have dedicated trainers, clinicians are needed for clinical services.

In service training financial and opportunity costs are high: recent increases in Daily Subsistence Allowance have doubled or tripled in service training costs (from 300k to 600/700/800 k per day depending on location and your level in system); most ZISSP trainings are long (20 days); in service training exacerbates staffing gaps in HF and management offices that are already understaffed, people away for training can't always be replaced; HR shortage means some project seconded staff lack counterparts for on the job CB. So they are just doing the job.

ZISSP has reduced level of training output due to cost increases, are there other strategy revision options?

MOH Structure:

HO: Statutory Boards, National Training Institutions, Tertiary hospitals

PHO: second level hospitals (general) and trainings institutions and DHOs

DHO: first level hospitals, health centers and health posts (they are responsible for HCAC and NHC) MCD will assume responsibility for Primary Health Care

In next 18 months before ZISSP ends, will MCD structure be fully functional? At central level, yes, but P and D levels will take time. In many instances, ZISSP counterparts have been transferred to MCD. Has caused some disruption. At district level, DMO is calling himself District Community Medical Officer, same people, essentially same office, but reporting not clear.

(How often) do DCMOs come together on a regular basis? Yes. For sector advisory meeting, all PMOs would come for that. If big launch happened, they will all come. The national planning launch in next month and a half, date not yet sent, hoping could happen before end of May. In terms of distributing instruments, ZISSP people in provinces could help. All ZISSP staff have emailed but also have connection challenges. Also don't have courier options in all districts. Focus on 27 target districts could come up with quick plan to reach all, or ZISSP can help disperse them through provincial staff. Getting back through an independent channel will have to be thought through. Do you bring your own people together periodically? Yes, mid-May. Also site surveys, if we structure it to have FGD.

Request for JDs for 3 seconded positions and 4 District Coordinators for SMGL.

Any potential role for ZISSP in facilitating better communication and coordination between the two ministries? Absolutely. We can kind of be a broker, unless the two PSs are talking to each other, for example MCD should be taking a stronger leadership role in planning cycle that is coming up, we were saying why don't we bring planners from MOH and have a brainstorming and also discussion of how roles of different entities are going to articulate in this cycle, they liked the idea of joint discussion and that ZISSP could be broker to make the request rather than having to come from a PS, which takes longer.

Liverpool and ACNM are not physically present in country. Next week ACNM will be in Livingston to do back up support for a training and will be there when the partners meeting happens. Would be good chance to meet with them and observe them. KP will provide the agenda. It's a bit high level.

6 hours driving to Livingston. And there are frequent flights. Maybe $500.

ZISSP seconded staff:

MOH or MCDMCH staff – formerly at MOH and now 1 HR person is still at MOH, others to MCD MCH (4) NMCC (6) – central level positions all filled.

Abt is prime contractor another malaria indoor spraying in Zambia; there is an activity funded under that mechanism and one seconded person for that.

Districts for other project are Eastern, Muchinga, Northern. So only Nyimba overlaps.

PHO: 7 CCS (recruiting 2 replacements), 9 MS, 9 CHC, 18 Logistics Assistants (driver and F&A support)

DHO: 5 SMGL coordinators, Active Case Surveillance Officer Lusaka

Gates is funding similar malaria project; our partner works on active case surveillance and their partner as well. Little pilot in Lusaka has given them the information they needed to design activities rolled out much more widely in Western and Southern Project with Gates funding.

Reason for 5 SMGL coordinators: 2 districts in EP; one is in PMO from EP asked for a coordinator at provincial level. Maybe interview the coordinator in the provincial office? PMO is a role model, excellent.

Malaria component of ZISSP could be a project in and of itself. Predecessor to AIRS project wasn't renewed in time, predecessor to ZISSP had a malaria component, maybe had there been a global mechanism available they would made a separate project.

Reason mission put this work in contract: there is good complementarity on technical side, but also competed all 4 major awards at same time, mission had a lot of on its plate, needed to find a place for the malaria work.

ZISSP project will end in December, right in middle of spray season, need another mechanism to continue the spraying.

Seconded staff are integral participants in the Ministry planning process at all levels. Seconded staff do belong to the MOH MCD-MCH or PHO. Sometimes we have competing needs, most often in malaria, structure of malaria program changed; in past ZISSP support was in training cycle and MOH used WB resource to fund operations. But many funding delays so decision made by PMI that in order to protect investment, would select smaller number of districts and be responsible for IRS aspects, case management ipti in more than 20 districts.

Follow up to training differs, done by trainers for EmONC and other using resources from ZISSP. May come from central or provincial level. In case of malaria case management, what we were working on was to orient them to revised guidelines, more to update them on what changed in most recent treatment guidelines, a lot of follow up happening through CCS and CCTs.

During annual planning process, ZISSP staff look for places where MOH priorities match ZISSP priorities and weave ZISSP support into HQ, PHO and DHO plans. ZISSP annual plans are guided by and shaped around MOH priorities. Looking for convergence, how our activities get woven into their plans. Our activities are perceived as part of the ministry activities, not separate. There are challenges to that: because our activities are already woven into plan of the ministry, we get our activities integrated in their plans, that's' basically a good thing. We are in a lucky position because of that. If a ZISSP activity is not seen as a priority in a district, probably won't be implemented in that district.

Planning is May. Cycle is June to August. Presentations to budget September. Long process.

What about ZISSP's phase out strategy in that planning process? Are you thinking about that yet? Planning process doesn't depend upon ZISSP, our support will be diminishing in some areas yearly. So this planning cycle will focus on what ZISSP will do in 2014. We plan on calendar year cycle, to match government's planning cycle.

CCS – under prior project HSSP, concept was introduced and MOH did incorporate that position into its establishment list and now has this position at provincial level. MOH still requested that USAID continue to fund CCS, have a wide domain, our objective would be to have a dialogue about position of CCS and MS to know whether there is a clear role for them to argue for the gov't to incorporate them.

MCD does have infrastructure on the ground in communities, so CHC position becomes a more living concept. This could be a role to be assigned in DHOs or otherwise located. ZISSP knows it needs to have this dialogue with Ministries.

With embedded staff project better able to understand and align with ministry priorities. Difficult to capture effect of embedded staff in building capacity with counterparts.

Personnel work as seconded staff and try to avoid being totally engulfed in daily tasks.

Seconded personnel seek to strengthen the ministry staff capacity and MOH systems in order to improve overall health system performance.

Does ZISSP have any CB milestones or measures? Haven't designed milestones or measure for CB being built by seconded staff. For ministry staff trained in particular areas, follow up process is to observe use of new skills.

Seconded staff do have work plans in terms of what they will do with their counterparts. Is part of annual appraisal process for staff. Most seconded staff have specific program goals that they are accountable for over course of year. For example, a CCS would be asked to support formation of clinical care team in agreed upon number of districts.

Do other projects in Zambia place seconded staff in PMOs? A lot of projects have data clerks placed in HFs to capture micro data that PEPFAR requires. But not like the ZISSP positions. CSH has central level seconded staff, in health promotions office but has moved with team to MCD, also have someone at NMCC.

Seconded staff try to maintain role at higher systems level but get engulfed in doing daily tasks as well mostly because work load is so heavy.

If ZISSP goes away, would that pull out pillar staff and create difficult vacuums? ZISSP knows it needs to start a dialogue especially at provincial level about roles of MS and CHC to determine whether need to lobby for their inclusion in entitlement list. Put this in the COP questionnaire.

We are interested to hear your comments on pros and cons on that, decision to incorporate them into entitlement list is made in the Cabinet.

ZISSP staff in Lusaka HQ

Sr Man Team 4

Proram Team Leaders 6

Program Officers 6

M&E 3

ZMLA team 6

F&A team leaders 3

Finance staff 6

Admin staff 10

Logistics assistant

Task 1: National Level

Repeats what is in TOR. ZISSP has baseline report about TWG in each domain.

MS doesn't have a direct counterpart because that function doesn't exist in the Ministry structure.

MS working on improving clinical care, program performance.

In some provinces PMO has told CHC not fair to work just in 3 target districts, indicates value of role.

Management and leadership training program through BRITE for PMO and DMO team with quarterly short forma training sessions followed by mentoring. Focused on 27 target districts.

In past there was a good system for engaging communities in health planning, fell away after central board of health dissolved, priority of both USAID and ministry to revive it, good potential with MCD to revive it. CHCs focus on community participation in health planning and BCC.

Three people here in ZISSP who are JHU staff working on BCC.

District Level Malaria Tasks

Support in 20 target districts: skills building, refurbishing IRS storage infrastructure, strengthening supervision and planning for IRS and other malaria control interventions, improving malaria case management, expanding FANC to cover all districts, implementation of IRS.

Project originally supported 35 districts. Doing quite well in this, it's operationally complicated but things going well. One person who is a seconded staff member is an entomologist, but also doing CB of MOH environmental health technicians at HF and DHO or sr. environmental health officers (at PHO) to do basic entomological surveillance. Some trained and more to be trained.

Other project AIRS buys insecticide.

CB for malaria case management is not restricted to 20 districts; IRS is restricted to 20 districts, but ZISSP also supports management meetings. There is a twice annual process of Performance Assessment, Provinces to Districts, Districts to HFs, ZISSP has tried to improve use of this tool for problem solving. We always chose places with greatest need for malaria work.

Clinical mentoring, QI, performance assessment and technical support supervision as follow up to address problems identified, all are tools that can help identify problems in the supply chain that refer problem to appropriate level so can be addressed. CCTs can remind HFs to increase order. Changes is happening incrementally, 18 districts are part of essential medicines logistics improvement program (EMLIP), eventual design is to transform whole system to 'pull'. Reagents are a chronic issue; JSI is one part of procurement picture but are not buying a sufficient quantity of malaria reagents for entire country for entire year. Various parties, some live up to commitments better than others.

Task 3: Community Engagement

CHCs work with community groups to build capacity for health planning, enable communities to develop local BCC plans based on a framework; support supervision for new community health assistant program, strengthen services delivered by CHWs by identifying and resolving gaps through PSAs?

Engage CBOs FBOs through grants to better integrate activities with health system.

Increase involvement of traditional and faith based leaders change agents for health.

Grants Program original plan to provide 30 grants to CBOs FBOs women led organizations to help build community ownerships for health and BCC. Where does grant funding come from? Grants and community activities draw funds from all sources.

Task 4: Engagement and Integration

Written into all contracts awarded at same time to encourage IPs to coordinate well and leverage resources. ZISSP has fostered stakeholder meetings at district and provincial levels to talk about their activities.

One thing in contract not done as a result of guidance from USAID is to formalize any GDA. Need to get it out of contract. Where does PRISM fit in with this? GDA was formed around HIV with PEPFAR funding. There are 14 major partners to GDA. Took 18 months to sign agreement. USAID and IP for PEPFAR (COMETS, may be still operating under no cost extension) and the 14 partners said not interested in forming another partnership through ZISSP. Willing to be engaged in other health domains besides HIV but would rather mechanism through mechanism of CHAMP or COMET to do it.

There is some private/public collaboration with malaria, but hasn't been formalized.

Not long ago CHAMP formed a new entity, built on platform of first collaboration on HIV but to expand more generally to health, ZISSP hasn't integrated with it but that is the logical way to go about collaborating with the GDA partners.

Has government recruited a second cohort of community health assistants to be trained? 2nd group started their year long training in October. Numbers? DCOF will get numbers. In terms of their distribution, who decides? ZISSP not advising on this. They are recruited from communities, get trained, go back to their communities, ZISSP plays no role. Do have data on where the trained ones have been placed.

This is a government program that ZISSP has provided support to but doesn't manage. Major funding for the first cohort came from DFID, ZISPP's role has been to help fund salaries of tutors.

Child supervisors curriculum is a government curriculum.

Noted SMAG training, trying to integrate with HBLSS; are you looking at entire HBLSS curriculum or just integrating a few modules? There are about 20 modules in the HBLSS training, so far 12 have been chosen as main community conversations around which training is happening.

For next consultations, request to see training curriculum and operational guidelines.

In every case where there is a national curriculum, that is what we use. What curriculum for CCM?

Health curricula are endorsed at TWG depending on technical area. Many guidelines are based on WHO guidelines, use global guidelines. ZISSP will work with MOH counterparts to adapt or revise for Zambia context, but are national training curricula used in nearly all training being done.

People selected to be members of NHCs have been trained as community volunteers. New cadre, CHA, is a paid position, hopefully were recruited from among people who were previously community health volunteers, there is potentially some competition between the two groups. Some people now being paid and others are still volunteering.

Training health providers who in turn train community volunteers for IYCF; training at community level the community members themselves. HF is usually staffed by one or two people, they conduct the trainings, either bring participants to district where there is training space or will do in community if there is a space for training.

Have people trained as trainers of SMAGs and also places where community members have been trained.

2 indicators for ARs – one about people who complete individual models, each model a different topic, then indicator about how many complete all 4 modules, attrition is a challenge.

Are there concentrations of people who have completed more training modules? A cohort from each province and cohort from each district (started with 9) will see one provincial and one district cohort for each province.

Per K, just finished baseline last month, doing data entry now. Have changed language about SMGL, now an aspiration to motivate people.

2nd ZISPP Presentation – Task 1 National Level Activities

Set up meeting to discuss training activities with Elijah and CB specialist.

HBLSS was part of original proposal from Abt to USAID that would work to introduce the method here, but there were already lots of things going on including big investment by UNICEF to develop a program manual for this. Idea was how can HBLSS tools and curriculum help strengthen already existing effort to create SMAG program. There is a logical complement in sense that SMAG program manual SMAG was lacking. Wasn't participatory training manual, no trainers manual, no Power Point.

ACNM has agreed to adopt the curriculum anyway, just put footer on title page saying this has been licensed for HBLSS use by ACNM. Since in the loop of revisions to protect legal copyright must insist on disclaimer.

Introductions: Program managers in meeting:

HRH Elizabeth Jere, HR Specialist, attached to MOH,

EmONC – Dr. Christopher

Child Health and Nutrition - Mary

Outgoing Team Leader - Dr. Muntinda XXX

FP and Adolescent Health Specialist on team not here today

HRH presentation

Requirement 59,998 HW but 33,900 filled as of 9/2012

Limited capacity of training institutions to produce required number and turnover and inequitable distribution

Who is working on strengthening HRIS?

3 key technical strategies

1. Adopt job based training and mentoring program?? CB in HRM, planning and records management
2. Develop modern HRIS: strengthen payroll management and establishment control (PMEC) System

Develop prototype of needs based HRIS for MOH

3. Support effective polices and systems to attract and retain staff and enhance staff productivity: ZHWRS, support implementation of new GRZ performance management package (PMP) and staff appraisal system

PMP provides for accountability and development of management skills for health sector and larger GRZ

PMP introduced new GRZ staff Annual Performance Appraisal System (APAS), replaced old Annual Confidential Reporting System

Key Beneficiaries: MOH, OCD, health training institutions

Major CB Activities: Reimbursed MOH for 119 HCW on retention scheme (out of 1,125 hw) as of 31 Dec 2012. Recruited ZHWRS administrator to provide TS to administer retention scheme for one year.

Beginning an evaluation to determine whether the ZHWRS is achieving its objectives (in terms of retention or health outcomes?) should have report by June. HW retention, tutor retention, contribution of MDGs.

TS and FS to DHRA for quarterly performance review meetings to assess and monitor annual performance against targets set out in HRSP 2011 to 2015.

Meetings led to better communication, increased team work, better planning, report, feedback at HQ, provinces, major hospitals and improved productivity in DHRA.

Request for copy of letter saying that ZISSP contributions have been significant. Team has letter.

Developed PMP implementation strategy, provided support to MOH to train trainers in PMP, trained staff in PMP, about 45% of MOH staff trained in PMP, add departments under HQ and some HF in P and D have started using the APAS. Continued roll out as result of trainers trained with ZISSP support.

All HW have individual work plans and targets agreed on with supervisors; never had before.

Conducted cap needs assessment for HRH Directorate. One of identified weaknesses was poor records management. Discussed problems came up with solutions.

Trained 53 HR staff, records management staff and registry clerks in HRM, planning and records management. Improvements in dispatch section, records keeping and tracking, MOH has since purchased computers for Registry Department at HQ to put in place electronic file tracking system to be rolled out to provinces in 2013.

Gave scholarships to 4 management staff at DHRA to Harvard course in HR strengthening, Have supported training of 770 health workers against life project target of 860 representing 90% achievement. Gov training facilitators have done the work, from Cabinet Office, TS division. Also for Rec Mgt. Produced the HRIS report that described steps to enable the MOH to have direct access to PMEC data. This system is not yet up and running. Encouraging Cabinet Office to bring this system over so it is decentralized. MOH must request reports from Cabinet Office. Cabinet Office has said will provide FS to decentralize the PMEC. In 2013.

Provided support to clean up payroll system, deleting staff no longer there, MOH was running parallel structures from old Health Board structure, now MOH, so have a payroll system with staff from old structure and from new structure, so have cleaned up and made current. Locked salaries = someone who absconds from their position, salary has been locked. Ghost workers. Ongoing issue.

Support to develop prototype of sustainable and standardized HRIs system. GRZ has expensive system, Cabinet Office came up HRIS to manage training data not yet rolled out to Ministries. Came up with needs for MOH and developed prototype which suits requirements. IT staff are developing system. Shows trainings, postings, staff who are confirmed, people due for retirement. ACCESS based, tailored to MOH requirements. IT says should have developed system in next 2 weeks, will need to be piloted in one province, then have TOT on how to use system, also developing a user manual. User manual, operational manual. What was the country using previously? This sounds as if everything was brand new.

Trained 80 provincial staff on WHO designed Workload Indicators for Staffing Needs (WISN) tool as step towards developing better health workforce plans. Used to determine workloads of HF, based on workload determine manpower required. MOH adopted this tool, ZISSP assisted the pilot. Piloted in Lusaka, trained 8 trainers, now piloting tool in 3 HF per province in one district hospital, one rural HF and one urban HF. In June or July will meet to learn results of pilot. Evidence based tool on how to determine manpower levels for HF. Trained staff have acquired skills and knowledge to effectively and efficiently plan for health workforce.

Key partners: Cabinet Office, MOH, MCD, MOLSS, PHO and DHO, CHAI - collaborated with them especially on clean up of payroll system.

Questions:
# of reimbursements for retention, 119? Is this life of project target? Where are they? ZISSP selected the 119 from ZISSP supported districts. Concentrated on hardest to reach districts. With doctors, tend to find doctor per district. This is a special scale up plan to retain staff in hard to reach areas. This is a voluntary scheme. Part of ZISSP's work is to come up with sustainability plan for this for MOH.

Are we measuring retention against contract period or some other number of years? Contracts are for 3 years. Have ZHWRS guidelines that say for 3 years. Evaluation will look at whether they actually stay for 3 years. When someone is posted, how often does DHO check to make sure they are there in place? Is there a tracking system? This is one of questions for evaluation, how is scheme being managed and monitored? What are monitoring mechanisms in place? Others in districts also want to go on retention scheme. Trying to encourage HR staff that monitoring these workers is part of their work. Will PMOs know about retention scheme. Most PMOs will understand scheme quite well, have been involved in past with this in previous Abt project. PMOs and also some DMOs have been trained in guidelines.

Can they provide us with list of these retained professionals? Can ask PMOs and DMOs where to find them. 1125 goal for all scheme. ZISSP supporting approx. 10%

Would HCACs know about worker retention scheme? Is there parallel with what UNFPA does for training? Another strategy to ensure workers stay in communities, train community based residents and bring them home to work, they stay in positions for a long time. May be difficult to collaborate the effect of retention strategy. With the UNFPA system community members know how it is benefiting the communities.

She is working directly WITH DHRA and Assistant Director of HRA and Chiefs.

EmONC: Dr. Chris Nwande? RH Specialist also incoming Team Leader for MNCH

No EmONC training in 2005? Institutional deliveries low, 47% in 2007? Need updated stats. PNC coverage low at 23% (also 2007).

ZISSP goal: contribute to reducing MMM by strengthening capacity to coordinate, plan, implement, monitor and assess national MNCH program interventions.

Key Strategies: Improve EmONC knowledge, skills and practices among service providers: strengthen EmONC curriculum, national training sites, support TOTs to increase pool of trainers, build capacity through training and mentorship of HW in EmONC, orient DHO managers and supervisors to EmONC to improve cap to support and supervise Basic and Comprehensive H Facilities.

Introduce HBLSS in target communities.

Advocate for strengthened MOH policy and program support for PN visit practices.

Key Beneficiaries: MOH, MCD, Med and Mid/Nurs training institutions, Docs, Med Licentiates, Cos, Midwives, Nurses and tutors, clinical instructors, community members

Major activities: establishment of 2 national EmONC training sites, increasing # to 4, 2 new in Chipata General Hospital in EP and Kitwe CH in Copperbelt.

20 HW in TOT to increase trainer pool

National Standard: to have 1 CEmONC and 4 BEmONC sites per district – move this. DFID and UNDP provided emonc equipment last year and this year at selected sites. zissp does identify equipment needs before training takes places. Role of clinical mentoring to identify these gaps. Is there way to solve problem if there are equipment gaps? EmONC specialist is seconded by ZISSP participates in distribution of equipment and feedback from provinces re inadequacies and overall coordination among EmONC partners. To what degree has ZISSP helped to roll out fanc? That is under PMI will discuss on Friday. Strengthening the IPT primarily, trainings in IPT at HW level. Also focusing on HIV/AIDS, STI, have come up with training module to attach to existing one.

Oriented 18 DHO managers and supervisors in EmONC and MDR from 6 districts. Ask about MDR policies and practices.

Total of 18 target districts have been oriented in EmONC/MDR with support from Results Based Financing project, being funded by WB. So ZISSP has done 6 and WB has done 12. Will do others in future. Has there been significant shift in resources as result of SMGL that has caused more attention to be placed on the 4 SMGL districts? Certainly in training aspect.

Trained HW in EmONC 253 against life of project target of 340, 74%, covering 33 districts including non ZISSP districts. Almost half have come from SMGL districts. What happened with EmONC and MN care efforts in the non SMGL districts as a results of shifting resources?

Supported post training technical support supervision (visits conducted by national EmONC trainers) to EmONC trained HW in 4 provinces. Developed tools for supportive supervision system for national EmONC training sites. Previously some training sites were not adhering to training curriculum and standards. Learned this from feedback participants, initial tools have been developed in process of finalizing supervision. Will we find information in TSS on how HW are performing? Yes, the tools capture that. Shared with management, critical areas of recommendation are shared with EmONC TWG to ensure

follow up at national level. Working with CCTs to come up with district mentoring teams for support for weak areas, eg use of partograph.

Provided training models and equipment to 3 Direct Entry Midwifery (DEM) schools. Chipate, Roan in Lwanshya and Inshanga in Chonga? Baseline needs assessment of all needs for training models and equipment. ACNM flew in to do this, developed tools together with General Nursing Council and principal tutors from schools. Training was done for tutors in the 3 schools, after training, models, supplies and equipment purchased, follow up technical support supervision visit.

Trained 13 nurse tutors and clinical instructors in Skills Lab Management from 3 DEM schools. TS to 3 DEM schools.

Supported development, finalization, and launch of clinical guidelines for use of misoprostol for prevention of PPH launched in Nov 2012. ZISSP has plan to roll out use of misoprostol in some of target districts, starting with 2 districts, in 2 SMGL districts, probably Kalomo and Nyimba.

Other partners are using these guidelines to train districts already.
ZISSP had part of role, pilots carried out by other organizations placed government in position to be ready to adopt development. Z contribution was to support development of the guidelines.

This wasn't on horizon at time contract was developed, rather an important opportunity that emerged. Partners are listed in acknowledgments. Partners are very collegial here, even across USAID/CDC barrier. ZISSP provided an external consultant for support of guidelines and supported the workshop where this was developed and agreed on. Also paid for review meetings, finalization meeting, printing of copies.

Key Partners: 2 Ministries, PHO, DHO, UNICEF/UNFPA/WHO (co-funded trainings with them)

ZISSP participated in DFID funded MH review. Large data collection to learn what was going on all over Zambia in terms of program successes, ZISSP provided a lot of background literature for their literature review and also contributed to information about what is happening, maybe also contributed to some presentations for one day conference. Have results of that report influenced any planning or decisions?

One activity left off is support provided for DEM assessment of relevance/performance ??? of certified midwives. Have graduated and been placed in different stations. Observation that cadres were not fitting well into other programs, trained in midwifery but being posted in areas where doing general nursing, so supported an assessment to check on this to report to inform curriculum review. Report will be ready by end of April.

MCD has created new newborn care TWG, different from Child Health, Safe Motherhood,

MDRs nationally a weak area. In 4 SMGL district, trying to strengthen this.

MOH collecting monitoring data that indicates whether skilled deliveries are going up or not. Can we get that data at central, provincial, or district level? Can get at provincial and district levels.

Generic question: you do most of the outcomes, eg trainings, expectation is it should make a contribution to impact. Why doesn't %age of deliveries in HF go up after all of these trainings? Zambia not on track for MDG 5.

National statistics on institutional deliveries are static, for program like ZISSP, through structures such as SMAGS do have an increase. But may not impact national statistics, as program we are mandated to show that implementing certain initiatives do contribute but there are many other contributing or confounding factors.

SMGL did a population based survey, results haven't been disseminated. There will be population data for those 4 ZISSP focus districts. Data collection was timely, was completed by early 2012, but different partners in different districts doing data collection, so sometimes data was different, issues in merging data. CDC was responsible for M&E component. Data may be shared at next week's meeting. Will share with evaluation team. CDC sub contracted to central statistics office, developed study protocol and tools through consultative process with partners. Getting ethical consent from Atlanta caused delays.

May slow down project but increase country ownership, to have more partners involved.

Adolescent Health – Francis Kapapa not here.

Adolescent Health Strategic Plan 2011-2015 launched 11/12
Adolescent Health training manuals for HW
Supported development of national standards for provision of adolescent health services
ADH Communication Strategy (under development)

Key Beneficiaries: MCD, MOH training institutions, communities

Trainings and TOTs, trained peer educators from Mpika and Nakonde RH/HIV prevention. There is criteria on who can participate, still being refined. HC staff choose them.

Do you think with this approach a 16 year old boy with gonorrhea would feel comfortable going to his local HC for treatment? That is the hope. YFC within HC is where adolescents can get treatment help. YFC should have health care workers assigned to work with adolescents and who have been trained.

Very little or a little? push from government side in terms of prioritizing adolescent health in country, when go to MCD and talk about it they will mention this. ZISSP has approached adolescent health in small way, focusing on 2 districts in one province, where there is concentration of support, idea is to learn as many lessons as possible and help MCD to scale up in other areas. Do not have strong counterpart on government side for adolescent health, so ZISSP AH specialist is filling that gap. Discussion to second this person into MCD, he will be going there. idea to strengthen this component within ministry.

If go to districts, don't have adolescent health specialist. The HW we are training for this may be nurse, clinical officers, other responsibilities. Approach has been to train identified people whom we can call national trainers, train the HW, eventually train the PEs and work through existing structures like YFCs in HC.

Several peer educators take turns staffing the YFC. Linkages from corner to trained HW. Including and targeting out of school and in school youth equally. High attrition rates in these programs in country experience.

Ask to see adolescent peer education materials that they use for peer education – don't yet have. Link with National AIDS Council will be at community and district level; they are linked with this through district AIDS task force/groups.

Guidelines were developed with Ministry of Youth and Sports, but not implemented, blueprint has become the adolescent health strategic plan recently launched. Everything starting over for adolescent health.

Key partners: 2 ministries, P/DHOs, Min of Youth and Sports is line ministry working directly with NAC for adolescent health, WHO/UNFPA, Pop Council, chair person for AH TWG is chair at NAC.

Anti AIDS clubs? Many in country. Both school and community based. High community support for some clubs, valued by communities.

Age specific intervention, possible to obtain age distribution on 77 peer educators?

Adolescents 10 to 19, young people 15 to 24 but political definition is up to 35 so peer educators may be older than adolescence.

If HW has reputation of being adolescent friendly, even if a bit older young people will go to them.

Family Planning: Hilda is FP Specialist

CPR 41% 2007. ZISSP goal is to contribute to increasing CPR – strengthen capacity…..FP interventions.

CBD program is quite recent, targeting districts where FP providers have been trained in LTFP methods.
CBDs mean to complement efforts of LTFP – to provide a broad spectrum of methods.

Standard curriculum for CBD training, efforts in 2011/2012, hired consultants last year to finalize.

CBDs work with HFs so get their supplies from HFs. Supplying oral contraceptives and condoms male and female. They are not yet popular or widely used but they are available. Decision made to allow them to do short acting injectables (depo) but scale up of this has reached stale mate some statutory bodies like Health Professionals Council of Zambia weren't comfortable, MCD trying to resolve this. Pilots were one in EP for this, showed

that CBDs were able to manage injectables. In training package, because reviewed previously, there is place holder, this is already in training content.

CBDs do they have other roles? Just trained for FP, but may also be SMAGs, or trained as TB supporters, may be multi-tasking.

Training data can show what other areas they work in, this is asked.

Mentors were picked from trainers pool, they are for HW not for CBDs. Who supports or supervises the CBDs? This year we will focus more on supervision of CBD, and orient district level supervisors as well as HF supervisors, some HF staff may not be conversant in terms of what the CBD role is. Will develop orientation package, so that staff at both of these levels are oriented to this program.

Which ZISSP seconded staff are involved in CDB training and supervision?
FP at district level is under the MCH Coordinator's umbrella.

They are thinking to reduce #s of CBDs to be trained.

Will CHA take on role of CBD? Possible sustainability strategy?

Key Partners include General Nursing Council

What other partners are doing CBD? Good observation to look at how ZISSP could link up with a program that is dealing in social marketing. – link gov services with private sector where it's appropriate.

3rd ZISSP orientation meeting 11 April

SGML DCs and ACNM trainers will be in Lusaka weekend of April 20th. Make sure hotel has correct check out date, 22 May.

Big group of program mgrs. Present: Emily Monze, MS Team Leader (9 MS); Victoria Mzonga, QI and CC Team Leader (10 doctors, 1 per province, but now have 7, 2 vacancies (WP 3 months, other more than 6 months, first hire didn't' stay long) and 1 new recruitment; Bernard Kassawa, CH Team Leader (9 CHC); Daniel Kwambo, CB Specialist; Benson M&E Team Leader; Julie Nbesha, Grants Mgr; Patrick Mwanza, M&E Mgr, Community and Mgr with Bernard; Mwanza BCC Adviser.

Asking for ZISSP's help with Ministry appointments.

Roman Kendi, Acting Program director for BRITE, Arthur XX, M&E Specialist for BRITE

Management and Leadership Component

MS are in 9 provincial offices,

Key areas:

- Asses and report on assessment of PHO management and technical CB needs

- Develop training and mentoring plan for PHO teams, including M& L training modules
- Develop reports on annual health planning process
- Report on DHMT CB needs assessment
- Develop baseline report son health resource mapping in target districts
- Annual updates o DH resource maps and capacity needs

Major activities: (Get these slides)

- Used MOH performance assessment tools for CB in: planning HRH procurement governance maintenance management and transport, internal audit and financial management
- Desk review of the 2010 PA reports conducted in 8 provinces
- Data collected during routine bi annual provincial PAs for 2010
- Short interviews with key provincial staff were held
- Findings guided development of CB plan for provincial and district and hospital health management teams by MS.
- Supported MOH to design training programs in gap areas: health planning, financial management, data management
- Supported MOH in adaptation of marginal budgeting for MBB package to district level requirement and initial training for 2 provinces using adapted MBB document
- Collaborated with BRITE/MOH to develop Management and Leadership Academy (ZMLA) course using a consultative approach with key stakeholders from central, provincial and district level.

NIPA is training institution

Development of reports on annual health planning process: Management Specialist Inception report 20102011 and 2012 planning process reports: address all levels; inform decision makers on existing gaps and areas of focus for following year, 2012 should be available soon.

3. Develop Baseline reports on health resource mapping in target districts: baseline report in 2011, incorporates copy of proposed resource tracking tool;
4. resource mapping activities conducted in 27 target districts alongside the 2012 national health accounts survey (NHA); NHA report not yet ready, currently being drafted by MOH.

Question re development of tool, ZISSP's role, supporting both development and implementation of tool.

Major achievements – Planning:

MOH keeps changing focus, every year something new comes up, so we have to revise materials.

Supported development and revision to 6 MOH planning handbooks for following levels: provincial, district, statutory boards, hospitals, training institutions, HC and community to align these to new MOH planning framework.

Supported printing and dissemination of all 6 handbooks to relevant levels where they are being used for planning – MOH planning standardized at all levels through the planning tools.

Working closely with MOH side by side to develop the handbooks, not farmed out to consultant. All these handbooks are complete and are in use.

Supported training of 90 planners in approved MOH planning process. These were the ones in place, posted. Mostly males are trained. Why?

Strengthened pre-launch meetings at all levels by assisting MOH and PHO to produce technical planning updates to guide program officers in planning process.

Support provide to MOH to train 43 health workers mostly males from Lusaka and Central provinces in adapted MBB concept. Newly obtained skills used in development of 2013 district action plans. Don't yet have the fully developed plans. How can team verify use of adapted MBB process?

Still developing the training package.

Supported training of program officers in data quality audits and basic information management. From these trainings the provincial statistical bulletins that provide summaries of PIs in key program areas. They are used as reference documents during planning of health programs. There were attempts in other provinces to do this, the will was there. Verify whether these statistical bulletins are new for zambia, thought they were already being done. On the web there is a USAID sponsored 2007 provincial statistical bulletin for north western province, these aren't new.

MOH has in 2013 adopted aid included development of SB and DQA guidelines in action plans.

Implementing DQA for HMIS data indicators. Being headed by MOH M&E unit.

Performance Assessment:

Supported revisions to MOH PA tools for district, HC and hospitals and aligned them to 2011 to 2015 national health strategic plan goals and objectives. SUSTAINABILITY

ZISSP hired consultant to assist MOH to finalize revision to the PA tools. Monitoring indicators re consistent across different key program areas, revised tools have been adopted by MOH for use in future PA activities starting September.

National Health Accounts (NHA):

TS and FS to MOH and U of Zambia Department of Economics to train 43 data collector in NHA data collection tools and procedures.

Logistical and TS to MOH - provincial MSs provided technical support to implement 5th round of NHA covering five sub accounts, helped to produce questionnaires.

Hired external consultant on behalf of MOH to assist with NHA data analysis and CB of Zambia NHA team through on site coaching for child health, MH, HIV/AIDS, malaria and TB. Team member supervised the tools development. Report being drafted to inform policy makers on future funding for the five program areas.

NHA looks at health expenditure by different technical areas and funding sources.

Is this done only for national level, or done also by the provinces? Not all provinces were targeted.

Central level has come up with allocation method, this is a national tool but there is also a tool that ministries use to allocate resources to the districts, then districts use those funds to develop their budgets. What are criteria? Population, disease burden, key indicators,

ZISSP contributed support to development of resource allocation to 2nd and 3rd level hospitals; this formula is being finalized now. Then we will see how formula is applied.

Everyone is planning based on 2007 DHS and then 2012 numbers will come out soon and there will be discrepancies. MCD receives separate funding from MOH; this may create some confusion about how resources get used at district level. How much funds should be distributed through HF, how much to first level hospitals, guide is minimum 10% of district budget should go to support community level activities.

For all these processes, ZISSP support has focused on creating a tool to enable powers that be to make right decisions, but program can't influence how much resources go to specific institutions. Our mandate ends with assisting development of tools/systems.

Had gaps with program mgrs. Z supported PMOs to train non-financial mgrs. and new ly recruited accountants in approved FM procedures. Sr accountants from gov departments inside and outside health system were used to deliver training, gov approved training materials were used. Training also addressed concerns in area of governance. What curriculum materials were used for this?

Anti-corruption and drug enforcement officials came in to do these pieces of training since curriculum doesn't include governance issues, eg anti -corruption.

Related to same problem of poor management of resources, there is a plan that MOH and cooperating partners have put in place. Developed a governance plan a MOU between cooperating partners, Elijah will try to get a copy. A few donors have begun to fund, others have pledged. MOH had few resources in this time period for districts, between 2009 and 2012. Districts received reduced grants and last year reports from service delivery was that many indicators went down. No outreach activities, immunization coverage and other routine services went down drastically.

Way they are implanting, what Emily was saying, working with MOH to develop these plans but must have donor resources to implement the plans.

ZMLA: developed M&L curriculum to address management gaps in collaboration with BRITE/MOH/NIPA.

6 core module: problem definition, basic principles of supply chain management, project/program management fundamentals, HR management, Finance and Budgeting and Strategic Information.

MOH has adapted ZMLA as approach to be used in MOH CB trainings. WHAT ABOUT MCD?

Medical curricula don't include management training.

Has BRITE developed new curriculum or used existing curriculum?

Did formative assessment and gap analysis of training needs; looked at other curricula, what was foundation that they adapted from? BRITE has had a generic framework with tools and concepts. BR has a model curriculum that they use in different countries. Originally developed in Botswana in early 2000s to support massive scale up of PEPFAR programs, also adapted in other countries. How they drew upon existing management curricula; need to speak to a principal from Broad Reach about their training materials and approach.

Is ZISSP trying to address the gender imbalance in terms of people trained? 360 were based on 9 target districts for first wave, supposed to roll out to all 27 districts, plus every province, defined positions that needed this training in 9 plus 9: 20 per (18) districts and provinces = 360.

For life of project: targeting 720, so have 18 remaining districts to train and 20 in each districts. Impact of increased (doubled) DSA.

Have defined positions to be trained, and are training whomever inhabits the positions.

Where gender imbalance problem originates: training institutions are pre service level may not be accepting equal numbers of males and females; there have been attempts at some of these institutions to achieve better gender balance; this is where it starts.

BRITE trying to build capacity of NIPA to deliver ZMLA curriculum so that this is sustainable beyond life of ZISSP.

Coordination and Integration with other Stakeholders:

ZPCT II Zambia Prevention Care and Treatment Partnerships also working in M and L CB their approach to training. Need to interview ZPCT II – harmonization of approaches is a macro issue to identify and address in report.

We have agreed that we can help them strengthen skills through our mentorship program. Also when need for more focused follow up training, eg on financial management, they are in 5 provinces, they are in all districts of 5 northern provinces. They have a more academic approach, more grounded in theory. BRITE is relevant to identified gaps, simpler approach.

Developed a collaboration strategy, being coordinated by MOH. ZISSP tried purposely to leverage different resources, where people are identified with skills gaps by ZMLA, can be referred to ZPCT2 for more intense follow up skills building.

ZISSP collaborated with CDC to implement trainings in DQA for district level POs.

Assisted PHO and DMOs to engage local NGOs and CBOs in health planning, implementation and monitoring process. Stakeholder and collaborative meetings. Some documentations that communities were involved in planning process. Where are records?

Assisted health care financing TWG to develop tools for NHA and resource tracking activities. Supposed to meet quarterly.

Questions:

NHA institutionalization – what will that mean?

Current concern is NHA demands a lot of resources to undertake the NHA. This year's 2012 survey, which ventured into 5 sub accounts, very big, then you go to partners not even getting information right, didn't complete the questionnaire, issue was isn't there a way of ensuring that some of the key data apart from that which can only be collected through surveys can continue being collected through a certain system, so that when time to do the NHA survey can focus on specific data that is not already collected. Not all relevant data being collected through HMIS system.

Difficult to collect expenditure data from partners. institutions should be able to document funds received by each donor and how much has been implemented. Want to be able to better capture this level of funding information.

NHA by design is done through surveys. What do we want to do that will change that approach so that it has become institutionalized? Some data has to be collected regularly directly from a funded institution. Shouldn't have to wait 4 years for an NHA to collect that data. Is country using financial part of HMIS? Cannot collect data from employers, from other ministries. Are there some components you can use?

For NSA sub accounts have expanded to five; collection of information for this system has a been a big headache; in past surveys have struggled to get the desired needed data. Unwieldy system. MOH has been trying to find an improved data collections strategy; donors want to share this level of financial data. Gov is saying let's collect this information regularly, eg quarterly. NSA wants to understand the sources and the uses. Donors knows sources, obligations, but also want to know how was the money actually spent. Same is true for gov, they want to know the commitments as well as the expenditures.

On issue of data demand and utilization – so many activities trying to address that. One on HCACs

Issue of provincial statistical bulletins. Was it the design of the project that these activities have to be scattered not done together? Eg, where trainings being done for districts to prioritize their areas. Are you not also building skills for them to prioritize their activities? Works better in other countries.

Re DQA: is there a framework developed to see exactly what ZISSP is contributing?

Current one they are asking for data from previous project HSSP. Luckily ZISSP could provide because it's Abt. 4 years not the ideal interval, just the de facto interval, every 2 years would be better, using more routine mechanisms.

For evaluation, this is a high level question but this is something the gov desires, would be useful to know how NSA is being used now for planning. Is being done nationally, assisting policy makers how to fund the sub accounts. Helping them to understand expenditures in different program areas, composites from different partners, once that picture is developed, helps them to decide how to best available resources. The tool is being used at national level, not the tools being used in the district. Is influencing planning decision at central level. What has ZISSP done to support the NSA process at the NSA tool at province and district level?

The data is now with MOH. MOH is now to generate a report on findings on the NHA survey. That report will assist them to make certain decisions regarding the funding to these sub account.

To distinguish between places where ZISSP has and hasn't put a lot of resources, NSA is a hangover from HSSP and prior USAID support, was strongly supported under HSSP, not a plan for ZISSP, but MOH decided on a plan that uses a lot of sub accounts, complex, must decide whether investment belongs in MH or child health. ZISSP got pulled in because MOH was partway through process and realized needed external TA and since Abt had done this in past, was asked to help. Wasn't part of ZISSP mandate or something they anticipated doing, but they have gotten credible results. Investing money in doing NSA with poor tools is wasted effort in the country. Previous mandate was to build capacity of MOH planning team that was working to develop the NSA. Including University of Zambia, working on this on behalf of Ministry. Challenge that has continued is frequent turnover of staff whose capacity is being built. Many people have moved, CB has proved a big challenge. Maybe going forward we can't guarantee that next NSA will have people with strong skills.

How to institutionalize? Could University of Zambia perhaps in future be given a contract for CB to continue this? Since they are already a government partner and have been involved? Institutionalization process can be a focus of a next procurement.

For gov answer lies in building capacity of the MOH team, as well as University of Zambia. They should both be the focus. this has been the focus of donors who have been trying to support, including our program. Our program is rich in expertise in NHA; actually training in quite a lot of countries, challenge in Zambia has been to build a team that would actually stay in both MOH and University of Zambia. We also tried to build capacity in University of Zambia have since left, don't know if they are coming back.

Main reason for 5 sub accounts, they were linking expenses to achievement of MDGs. Maybe we are over exaggerating what our role is. A couple of short term consultancies is not a big deal. Even if there was an institution here doing the nitty gritty work, might still need a consultant now and then to design tools, do trainings, etc. In this case a 47 page instrument was already designed and circulated before they asked for TS.

Is Zambia Management and Leadership Academy a localized institution or a training program?

Are MS doing other kinds of financial support activities? Is so, what?

Program is co funded by Merck Foundation. Deal that was brokered between USAID and Merck Foundation. Merck believes you can invest as much as you want in specific aspects of health but unless you have good leadership and management it won't grow, had idea of funding in one country to show what management and leadership could do. Point of collaboration is at BRITE; they give money to BRITE. For same project. BRITE manages which share of costs are attributed to Merck and which to ZISSP, and they bill both. Only for ZISSP districts. Speaks to why foundation of curriculum is what it is; BRITE is entity that Merck had already selected for this training program; they were not originally a ZISSP partners, USAID brokered this partnership.

Z didn't go shopping for best curriculum; Merck had already done that and chose BRITE and USAID said wanted to attract the Merck (leveraged resources) to Zambia.

How often are DQAs conducted, who comprises the team, where can we get a report?

Provincial teams go to the districts. So CDC team and Provincial Sr.Health Information Officers have been spearheading this and ZISSP has provided financial support to do trainings and the visits to sit and look at data. Supposed to be done quarterly.

Where would records be? Should be at both P and D levels. Teams ask for copies of dqa at both provincial and districts levels. Add to bottom of interview tool? Would be more useful at district level.

THIS YEAR our plan is follow up these trainings.

DQA started in 2012 with ZISSP, wasn't happening before, part of the realization that you can't plan without good data. Initiative was from MOH, not from donor.

Had a gap analysis, saw weaknesses, refer to gap analysis November 2010.

MOH wants to develop a guideline in DQA so there is a uniform way of conducting data activity. CDC will be part of this. MOH has already started more discussions on this, if you are around, sit in on meeting. Picked up some common language.

Activities that we are referring to were started by the MOH, started with PMTCT, going there quarterly to check on data. No system or formal methodology. We need to be careful to check whether each technical program checks on relevant data, or is it all coordinated into one package? This was started not by PEPFAR but by M&E unit.

Does need to be standardized.

Clinical Care Specialists

Currently have 7 positions filled, having turnover. Working at all levels in 9 provinces, now no one seconded I n10th provinces, but that is being covered by one of the CCSs.

QI:

QI committees to enhance quality of health service delivery. identify health service performance gaps from HMIS, PA, performance review meetings; conduct root cause analysis; identify interventions; monitor and evaluate performance

TA provided during annual provincial and district planning to identify areas of priority for next planning cycle based on local health indicators.

PA conducted bi annually to DHOs and HFs to identify health performance gaps (standard tools for all levels with selected health indicators for all health programs)

TSS is a follow up to PA to address identified gaps and can take several forms, including clinical mentorship.

This is done even at health post level, but not all facilitate are covered in a given period. Maybe only 2 weeks in which to conduct PAs, first have to assess district office, then hospitals, then will go to some but not all health centers/health posts. Next time they will visit others, but sounds like many may not get assessed.

Component of community within tool, but process does not include community member participation or feedback. But in some places they may be invited.

Development is underway for a mechanism for communities to assess their HCs, greater focus on QI, need to have HFs accountable. Look at whether to recommend support for development of this community component of pa, and harmonization within existing performance assessments.

Quick background: during days of Central Board of Health there was an advisory body powerful could hire and fire, now what is happening is they are working their way back toward greater community participation, but doing so cautiously because they don't want to get back to where they were before. There was a time when communities were deeply involved and had power, and depending on community they continued to work and fell apart.

Households are being assessed on all health areas, from environmental to disease patterns, information collected by CHAS. Look at how all these pieces do or don't get harmonized, could be better harmonized.

Health program performance reviews to assess performance gaps according to set standards and identify solutions. Quarterly provincial activity with DH program officers. Evaluates selected health program indicators from each district, identify performance gaps, achievements, share best practices, challenges, identify areas for TSS and mentorship in all programs.

MOH has selected key indicators. Outcome indicators. Get the list to put in the work plan. Get the HMIS indicators.

TA during annual provincial and district planning: to identify areas of focus for coming year based on evidence, performance issues at level provincial and district and HF level; TA to enhance use of HMIS at each level; ensure identification of cost effective health interventions; CCS facilitate the view of clinical areas in work plans from districts and HFs.

Provincial or District integrated meetings – the MSs and CCSs collaborate for these meetings. Looking at financial component and HR components and health indicators. Ask questions about what this integrated planning actually looks like.

Clinical care mentorship to improve health worker performance.

A mentorship package was supported by previous project but not supported to ART program, so need for mentorship in clinical areas not only for ART, also other support areas related to clinical care.

Formation of multi-disciplinary CCTs at P and D levels: identify people strong in components: pharmacists, lab personnel, nutrition, nurses. ZISSP supports them to hold meetings.

CCTs review HMIS, PA, performance review reports to identify mentorship needs and assign appropriate mentors to a particular HF or HW. That may come from provincial level. How to ascertain that qualification of mentors are up to date and up to speed?

Add questions about this to health facility checklist. Make it a tool for this team.

Where can evaluation team find mentor team members? ZISSP has developed CCT guidelines.

CCTs facilitate the maternal death review. MDR committees are found at each district, chaired by DMO, some members may also be part of CCT who have to follow up that case and fill out the forms. Done at district, HC, community level. Add question to DMO interview and health facility checklist: do you perform maternal death reviews at this health facility? If so, who initiates, who conducts? Where are review forms submitted?

Have you had any maternal deaths in the past? If yes, was a MDR conducted? If yes, who conducted it and where was data submitted? Look for this at district level not facility level.

If answer is no, ask if you have a procedure in place for MDRs.

DMO will be notified, will call committee who will conduct the review. SMAGS will inform HC if there is a community death, and HC will inform DMO.

In terms of actual MDR, this is more focused on those deaths that occur at hospital and HF level.

The form also asks for deaths in the catchment area; this is part of SOW for SMAGs.

CCTs facilitate clinical meeting and health symposia as a QI strategy, topics are based on identified gaps in health service delivery, and also used as a forum to share updated guidelines and information from MOH.

Where find QI trainers? At provincial level. They have trained 515 HW, will train more this year.

Facilitating formation of QI committees in 5 provinces: Team meet with qi committees? Could set that up through CCS at provinces. Do committees have a scope of work?

Is there 100% overlap between CCT and QI committee? Yes a lot, because limited #of people from which to choose. The TORs for CCTs and QI committees are different. Clinical mentoring is one of several strategies for QI.

Are mission and other private sector hospitals included in assessments? CHAZ institutions are under the district management.

Government is specific about inclusiveness of all stakeholders at Provincial level QI for QI committees.

HF supported by CHAZ are integral part of national health care system, receive funding from MOH.

Under Clinical Mentorship

Facilitated review of CCM operational guidelines and training curriculum

Development of mentoring tools for different health disciplines, generic

Facilitated national launch of reviewed QI training package

Facilitated formation of CCTs: 6 provincial CCTs and over 38 district CCTs in 6 provinces.

Trained 24 provincial mentor trainers and 641 multi-disciplinary mentors

In past year Mentored: 3,024 HW through 4,012 mentoring sessions.

Previews: supported 13 quarterly performance review meetings since 2011

422 CLINICAL MEETINGS/SYMPOSIA HAVE BEEN CONDUCTED 422 –provide continuous staff development strategy

Coordination and Integration

Collaboration with CDC through MOH to develop QI guidelines and review training package, also AIDS Relief and ZPCT2 were involved, also with CDC to train health workers from SMGL districts EP in QI with TA from HealthQUAL International. What is in that training package?

Interview CIDRZ in Nyima and in Manza would be JHPIEGO for training on clinical management.

MOH Perception of ZISSP Support

Evidence of ownership in several ways: get the slide.

Look at where MOH has co-funded any activities as evidence of progress toward sustainability. This QI area has evidence of good progress toward sustainability.

Success story mentioned orientation in basic anaesthesia – who is doing that training? Also pulling in other training resources to work with CCTs, eg for basic anaesthesia.

Grants Program: One of the 4 main areas of the community component.

Other community components are Community Health Planning, scaling up of SMAG and health promotion program (BCC).

For CBOs and FBOs that are implementing health communication and service delivery interventions.

Criteria: can be found in AR.

Demonstrated capacity in health promotion, BCC, health services in 5 areas, adolescent health.

Appraised by Grant Support Teams (GSTs) t district, provincial and national levels. GST members include MOH, ZISSP, Provincial and District Health office staff.

USAID through COTRO approves, total 3.6 US million to be disbursed in 3 cycles. Org can receive 40 to 100,000 and have up to 12 months to implement their activities

11 grant recipients awarded for first cycle of disbursement amounting to USD 975,529.05.

ZISSP mapped potential recipients with MOH, PHO, DHO as well as gap in information and services.

Developed annual program statement for Grants Program and planned grant making process based on mapping.

Developed guidance documents: manual, analysis plan to identify grantee, orientation package for GSTs, annual program statement, training manual, organization CB training manual, BCC framework.

Target populations: women and men of child bearing age; under 5 children; adolescents; PLHIV; traditional leaders.

Didn't look for equity across 5 health technical areas, looked at the criteria and qualifications above.

Have developed MOH/USAID approved (and owned?) systems for grants program.

Grantees are community level trainings in: SMAG, community health planning, malaria rapid diagnostic testing, adolescent RH and PE, HIV/AIDS ART adherence counselors.

Grantees:

Keepers Zambia Foundation, health planning MH

Childfund Zambia MCH Nyimba

CIDRZ, community response to primary health care, Luangwa

Sinazongwe WV ADP malaria, maternal and newborn health, FP, CH and Nutrition and HIV/AIDS

Thandizana CB HIV/AIDS prevention and care MH Lundazi SMAG

Serenje Pastor Fellowship FP, SM HIV, community participation – Serenje District

NZP+ Mwinilunga District, support groups

Kalomo Mumuni Center access to maternal, neonatal and CH

Diocese of Mpila HBC P reduction of malaria diagnostic testing

Groups Focused Consultation community participation in health planning Manza District, Luapula Province

Community Integrated HE Program (COIHEP0, Lwanshya District, increasing health seeking for HV/AIDS

Grant delays: before disbursement, APS and grants manual had to be approved by USAID before could disburse funds. Process included vetting at community, district, provincial levels.

Participatory process. Application deadline was Feb 2012. First awards were approved July, but disbursed September. About 7 months ago.

USAID approval process was faster than grants review process.

For 2nd round not going to go through this solicitation process, going to pick from what was recommended by MOH in first round. There was a scoring process, look at grants manual and orientation package, scoring included desk appraisal and field appraisal, when made recommendations to national GST, they did another round of scoring.

What capacity assessment undertaken as part of the grantee application and selection process?

Review guidelines for this information.

Initially targeted only districts. When Ds and Ps were selected, asked them to prioritize recommendations based on district gaps.

Having committee helps to address issue of favouritism. Committee and clear rating process.

Also had 3 levels of validation – D, P, N. good checks and balances.

What about the other 169 applications? Desk appraisal was screening process. Rejected those that didn't meet minimum criteria. Also had a bidders meeting, so had records of all organizations that showed interest at bidders meeting.

GSTs not only select grant applications for funding but also provide TSS to grantees – what does that include? Established monitoring and support system. What does that include?

Funded on a monthly basis; expected to send monthly financial and program reports. Training manuals were for grantees, trained in grants management including FM and reporting. Sub contracted an organization to provide this training, received reports, going to change this methodology for next cycle.

Which documents are grantees supposed to have? Org CB training manual for grantees, next step is to train them in the BCC Framework.

How to look at effectiveness/impact at community level – gov doesn't have good systems for capturing impact at community level; in terms of grantees meeting their mandates, in initial proposal have objectives and indicators, can see if they were met.

How to look at accomplishments within the BCC framework?

These grants are meant to complement the other work ZISSP is doing at community level: eg, # of trainings for ZISSP, so these activities fit into the larger targets for this, making sure they are using the MOH standard curriculum, eg for ICCM, or for IYCF, ZISSP as part of monitoring makes sure they are using the curricula correctly.

The CHCs work in collaboration with the GSTs to monitor the activities and ensure QA especially for trainings.

Initially saw some cash requests saw areas where organizations weren't planning according to ZISSP standards. Eg, trainings that were too few days. So a dialogue to ensure alignment. Benefits the organizations in that they are better connected to the national framework.

Already ZISSP is thinking that need to invest in more resources for CB for grant organizations themselves in addition to just giving them financial resources.

M&E was indicated as a blank in capacity; training alerted CBOs to what they needed to be able to do.

In terms of outcomes: already alluded to linkage with SMAGs. Big targets. Tomorrow will talk about other community activity targets. How does this fit into the larger community strategy?

Believe their monitoring and support system is working well; when they note gaps they don't disburse funding until it is cleared up.

Monthly disbursements, monthly reports. Grants being awarded under a contract. Funds aren't dispersed until others are liquidated. This is Abt's procedure for handling grants under contract agreement. Also have internal delays for disbursing grants monthly.

On time reporting rate to date? About 50%. Grantees can't implement all their activities according to plan due to delays.

Delays are at various levels, in spite of CB efforts up front, eg on how to write report, sometimes monthly reports are incomplete or not done according to guidelines, causes delay.

What can team recommend about more efficient grant management process?

There is a project winding up now called Local Partner CB Program, good project, trying to figure out how to do successful small grant making. FIND OUT ABOUT THIS PROGRAM.

4th meeting with ZISSP Friday 12 April: Community Health

Community Health Planning:

Community health resources mapping conducted in 2011 to guide planning of community interventions.

Held workshop with MOH, PHOs, DHOs and communities to develop strategy for community activities based on results.

Community Health Planning – ZISSP facilitated revision of handbook to guide process of engaging communities. Also provided training to HCACs and NHCs to foster activities participation in community health planning. ASK ABOUT THIS DURING FOLLOW UP TRAINING CONVERSATION.

Roll out of SMAG program: platform for communities to address FP, pregnancy and newborn health. Main role of members is to provide information and make referrals.

Partners: ministries, pregnant women and newborns: NHCs mobilize community to access health services, HCACs provide link between health care systems and communities, SMAGs mobilize communities to respond to issue related to safe motherhood; traditional and other leaders provide leadership for effective community engagement.

Achievements: Trained 1,253 HCAC and NHC members in community health planning; printed and distributed revised Community health Planning Handbooks for use during 2012 planning cycle.

Expansion and formation of SMAGs in 10 of 27 ZISSP target districts, working with ACNM. Trained 115 SMAG trainers, now have master trainers in the 9 provinces and have at least 8 district trainers for each of the 9 provinces, and 1,046 SMAG members against life of project target of 3,000 for 53 of 135 target rural HFs Sustainability step. Also have some in the 10th province, in Machinga.

We are talking about male involvement in area of safe motherhood. Males have historically been a stumbling block, so male involvement in SMAGs is notable change. Why are men willing/interested to join SMAGS?

Also have developed monitoring tools for SMAGs, data management tools being used to monitor and evaluate SMAGs program. Ask to see these tools during field visits. Adaptation of ACNM HBLSS training curriculum is nearing acceptance as a Zambian training manual (did ZISSP have key influence for this or was it eg a TWG activity?) Adapting it and calling it the SMAGS Training Curriculum, using not all modules (see previous notes). MCD eager to have a standardized Zambian training curriculum for the SMAGs. Have other players who are training the SMAGs using other curricula; this will harmonize the national approach.

Provided incentives to SMAG members: to most members trained, 850 of 1,040, materials including bicycles, uniforms, megaphones, umbrellas, raincoats, other items. First time when community members have received so many materials.

ZISSP contribution to CHA program:

MOH recruitment process for CHA –

Sample: 165 communities in 48 districts in 7 provinces, 2 CHAs nominated per community.

Recruitment: advert, application, short list, interview, nomination, final selection, intake; person should have attained grade 12.

2011-2012: in collaboration with MOH visited schools on monthly basis to hold meetings with school management to assess progress and come up with solutions; facilitated development of academic and administrative regulations; facilitated affiliation of training school to U of Zambia School of medicine (Examination Council of Health Sciences); led process of review of pilot curriculum before commencement of 2nd cohort of students, in Sept to Dec last year. Facilitated development of curriculum for CHA training supervisors 9 health centre in charges) and subsequent training in seven provinces. This was a major contribution last year. Facilitated training of 207 CHA supervisors, paid 10 tutors salaries and benefits.

2013: led orientation and formation of gender club in CHA school with participation of all 292 students, to enable students to take gender aspect to community level.

ZISS will pay 10 tutors salaries up to March 2013.

ZISSP has been mandated as Focal Point organization to coordinate the SMAGS program at national level. Meet Cecilia Tembo in Luangwa? Success story.

When communities are well oriented and empowered, capable of effectively advocating for their health needs.

Challenges:

Retention and motivation of SMAGS members; unable to provide support materials to all members.

Irregular TSS to community volunteers by HF, shortage of trained staff at HCs.

Inadequate gov funding to support community level activities. Most community level activities are supported by donors, so sustainability questionable.

Suggested Improvements: develop guide to assist 2 ministries in community health planning. Zissp have drafted such a guide, then orient DHS and HC staff to simplified guide.

Questions:

By end of project how will you measure contribution to HR program through support to CHAs?

CHA program came along the way, not part of original ZISSP plan. Came out of recent community health strategy approved by MOH, one component was introduction of CHA school in Ndola. When this was introduced, Ministry asked for assistance, how ZISSP got involved, for training of 10 tutors, training of supervisors, financial support came from PEPFAR partner implementation framework, bilateral agreement between USG and Gov of Zambia to provide supplemental funding to strengthen specific gov programs using PEPFAR funds, one program was the CHA program. An unexpected mandate, looked for mechanism to funnel funds and ZISSP chosen.

In typical training function, one way of measuring success is on output. We can say that we have contributed to graduation of 307? students. When this started in June 2011 ZISSP already involved, found certain things in curriculum that we started to help improve, found there was no examiner for program, went in and looked for an examiner, organized the affiliation with U of Zambia. Had 100% pass rate in first cohort. IS THIS IN THE ZISSP M&E PLAN?

During pilot, it was 47 districts in the sample.

Is there a master list of SMAGs, ensure no duplication of efforts. ZISSP knows which partner is working with SMAGS in which districts and which partners have provided which incentives. That was done at level of MOH, realizing the need at community level is really vast. If you look at all SMAGS attached at the various HCs, have had partners working in areas for many years without saturating communities, so ZISSP started with the mapping exercise to find out which HFs that were not yet taken up by partners.

Maybe could meet up with SMAGS supported by other partners.

Gender club: have you incorporated gender as training topic for any community activities? Yes in CHA curriculum. For SMAGs? Inserted in revised curriculum for CHAs, 2nd cohort will receive a strong component of gender.

If at community level males are going to be seen talking about RH issues strongly, community now looking at these issues as not just women's issues. Some topics that are covered in SMAG training, and HBLSS approach, there are community meetings, and discuss what men should be able to do in areas that affect women's health: pregnancy, childbirth, newborn health.

Training can help volunteers to confidently discuss gender issues at community and household levels; this can be a training skill included in the training. Per ZISSP, it is.

For SMAG volunteer criteria, we have aimed for 50/50 gender approach. We pick SMAG members, we pick them from existing structures, so can include community health workers,

TBAs, traditional village headmen or leaders. In most cases they are men. Other community volunteer structures, eg PMTCT counselors. Or health promotion people. We look at how communities are zoned, try to ensure that both males and females are coming from each area. In some cases can only find females, in some cases only males, but overall aiming for gender balance.

Add question to FGD about how women volunteers feel about men volunteer and how community members feel about male volunteer.

Every month groups bring SMAG reports to HC. Have indicators for work they are doing in community, using pictorial indicators. Able to see through registers how many people reached by SMAGS, THIS IS A ZISSP brainchild working with ACNM. One thing that was missing was removal of data from primary source - eg, if you have 7 zones you have 7 registers coming to HF, so needed a data aggregation form, so can see all data in one form. This is how SMAGs are managing. One thing we quickly note is increase in institutional deliveries. How many are a result of direct referral? Has project collected data from HF, Ask to see this data. Nyimba would be good to see this data.

Do any pictoral indicators reflect increased in male involvement in maternal health?

How can changes in male attitudes and male involvement at household as a result of SMAG activities be measured?

Before actual training, we conduct a pre-assessment exercise, to get baseline. For what data?

There is a lot of pressure on skeleton staff and their workloads have increased as a result of SMAG activity?

DHOs are expected to maintain bicycles. ZISSP is supporting DHOs to do what they would have done with sufficient financial resources.

About how much time should a SMAG volunteer spend being a volunteer? What is time commitment? At least 1 to 2 hours meeting maybe twice a week. Not just meetings, sensitization, but also escort pregnant women to HF, also visit newborns. Ask re-focus on PNC in SMAGS and cha trainings and work. add question specifically on PNC in both FGD questionnaires if not already there. Key emphasis for SMAG volunteers is community sensitization meetings. One topic per meeting.

Part of JD is to do household visits, they are documented.

Re CHAs, 20 of ZISSP districts are involved in this program. They are scattered, based at health posts.

Gender distribution of Grade 12 graduates? 51 male/49 females for CHA cohort, selected from rural areas.

In Lundazi, can find SMAGs trained by AfriCare. Manza, PLAN, UNICEF, UNFPA.

Aiming for 60% community coverage for SMAG groups.

Financial support for CHAtutor salaries ended last month –what happens now? There was a promise from GRZ to take over these salaries.

What changes do you want to make in male involvement in RH? Want men to put money aside during pregnancies. First change mind set of male volunteers. Taking part in FP. Help during emergencies. Qualitative research for SMGL cites men as barrier to women seeking ANC. If women are seeking ANC earlier and having FANC visits, suggests men are changing. May have other secondary data that is suggestive of change. We do start seeing increased in ANC visits, men escorting their wives.

SMAG data is not in general register. Some data might not be in the registers. Look at registers and think about how other data could be documented. During development of tools, have had discussions on how many data parameters can we include. Get data collection tools for SMAGS.

The report has an annex; and data aggregation forms are there.

Refer to Report from ACNM.

Also will show us what tools we should look for in field.

BCC Program

Structures and processes to plan BCC activities, increasing community involvement.

BCC Framework: reviewed existing communication strategies at national level (HIV, Safe Motherhood, there was no FP strategy).

Assessment done in 3 provinces, 6 districts, looking at BCC materials, activities, coordination, planning, harmonization and synergy of efforts.

BCC Framework interventions:

CB for D health promotions focal persons; ToT to facilitate formation of IEC/BCC committees at D level, CB and training tools for drama, master trainers for community drama, CB of community drama groups

Does framework indicate key desired behaviour changes and how they will be measured and in what time frame?

RDL Program for SMAGS add question about this to SMAG FGD tool.

Started in 2011. Used to supplement MOH training, provides refresher education. Not really a BCC activity, a CB activity.

Does this not also reach community members beyond SMAG volunteers? So used as IEC mechanism?

Have produced radio program in English, 6 programs, also being translated into 5 more languages.

Follow up activity is formation of listening groups; once program starts airing, LG will consist of 10 members, 2 are already trained SMAG volunteers, will have discussion guide to serve as teaching tool So serve 2 purposes: educate groups and reinforce SMAG training?

Is this different from behaviour change, more IEC and CB blended, although educational messages may promote change.

Creative brief – document used to share with production houses and stakeholders to strategize and develop materials, gives direction.

Major Achievements

Developed BCC Framework

Trained Sr Health Education Officers at P and D levels in 9 provinces and 72 districts to build leadership skills for BCC programming. Meet with health promotion focal persons during field visits.

Helped districts to form IEC/BCC technical committees to strengthen BCC programs, coordination, implementation in 27 target districts.

RDL program: Have developed a flip chart for use with home visits and community meetings. Pictorial but also narrative key messages and matches radio program content. Two posters, one on male involvement, one for women during pregnancy. Will also provide discussion guides, bags.

Drama Capacity: CB for drama groups to write scripts and focus on desired health outcomes, behaviours, barriers to communication. Trained 36 D Master Trainers to further scale up drama CB at community level. Total 804 in drama BCC.

Success story emphasizes harmonization and coordination, involvement of DCO, traditional leaders, churches and district education board in sensitization and mobilization for 2012 measles campaign.

Partners: MOH, NMCC, MCD, Communication Support for health

Role of CSH: develops national level interventions, training, but ZISSP provides framework for translation and localizing these strategies at local level.

Integration of BCC activities into MOH annual planning cycle with separate budget line enables commitment of resources for preventive and promotion activities at district and community levels.

BCC efforts to promote demand for health services can stress HF that are already overloaded or understaffed. Always a risk with community level health promotion activities.

Plans to have in line survey to look at program results.

What kind of behaviours might you measure? Earlier ANC care. Do messages cover all 5 technical areas? Bcc Framework includes messages. Look in Framework under key essential health actions.

Stakeholders can localize messages.

Was any baseline done? Not for BCC Framework. The end line is for the RDL program.

For drama, will develop tools that will help us look at validity and fidelity of activities.

These and other activities are influencing community demand at local level; how can you attribute the radio programs and drama interventions to overall change?

Wanted to do baseline, costly. For RDL want to have a pre assessment, will essentially do a pre and post knowledge assessment for each program. There are intervention and control districts. Will be airing in Kalomo, Manza, Nyimba, Mamba, Kalalonga?, Luanshya.

Will use existing community registration.

Last year did CB of community registrations prior to airing programs.

Communities prefer local radio stations, know the voices, ZNBC has wider national coverage but doesn't' reach all communities.

RDL is what ZISSP has brought as an innovation, this will target the already trained SMASg, first they are trained in normal curriculum, but it is Z's initiative to complement existing skills and knowledge.

Want to show the additional effect of this innovation. Will have certain SMAG groups that also get the RDL activity others will not.

Will look to see if this additional activity makes a big difference in outcomes. We want to bring innovative practices.

Radio programs intended to open dialogue with community members who have heard the programs. Operational research.

Listen to radio program.

MOH realizes importance of strengthening interventions at community level, has been on board with this planning. Di of PH and Research has emphasized the need to be strong with BCC.

Interview director of public health and research?

We keep mentioning community structures, NHCs and HCACs, they were there at time of Central Board of Health. Do we have systems in place through MOH in terms of how often they should appoint these committees and who should sit on them? In past there was a mandate to make sure they existed and who should comprise them.

MOH strategy puts CHA in loose position in related to committee structures.

If you go to District, there is a recognized body a District Advisory Committee, then at HC there is a HCAC, NHC have never been abolished, things went silent, these are structures that worked well in past, current system still recognizes them, trying to revamp. Meet with dac during field visits?

In your community health strategy, how are you addressing the NHC? What is their role? They do play an official role.

If you look at reporting structure, CHA reports directly to parent HC. No documentation that CHAs would attend HCAC meetings, even though this person is collecting all community data but not member of NHC or HCAC, so there is a coordination gap.

CHA is guided by a national strategy that should look at coordination of all resources.

If you look at strategies that exist, these existing strategies are older. As system matures, maybe this can be addressed during revisions.

This has been identified. Even CHAS find themselves not connected.

NHCs are part of that volunteer structure and in most districts or HFs you find high attrition rates.

We have a document on community mapping of existing structures. On the black jump drive.

Currently with community planning handbook development, also looked at ways to strengthen these structures where in place but not performing well. came up with division of roles and responsibilities.

As talking with communities about community planning, have also discussed these roles and recommended representation on NHCs and HCACs. MOH has embarked on this process. Has to be on-going due to attrition. Even if NHC performing well now, may not be in future.

Currently team working districts is doing this as part of community health planning support. Who is district focal person to keep this going? There are FPs for this.

With movement to MCD, other activities are already taking place at community level. Health promotion activities have brought new dimensions. What if MCD requests ZISSP to harmonize these various activities at community level, eg OVC? Know MCD moving toward coming up with one reporting system for community activities, that structure is built around existing structures.

1.5 years ago USAID floated a project called ?? strengthening local levels, has never come out since Ministry started to split. Where are these resources? ZISSP may become the vehicle to channel those funds. Who does M envision as the sustainable community FP for reinforcing community structures?

Which ones have you done together with CSH and has there been cost sharing between two projects?

Malaria interventions and training:

Behavior Centered Programing Approach was done by CHS, ZISSP helped to develop curriculum and do a national TOT, but ZISSP CHCS did district level training. Add this to training questions.

CHS leads USG partner stakeholder meetings, ZISSP is there. Cost share the national IEC TWG with CSH. CSH participated in development of BCC Framework and design of radio program document for first year thought we were seconding staff to them, so much collaboration on communication strategies. BCC Framework easier for ZISSP to work on as a result of this earlier collaboration.

This Zambia's first health promotion guidelines: with WHO, other partners led by MOH.

BCC, RDL, drama only, IPPT with co-investigator, purely supported by ZISSP. All activities discussed today were ZISSP led and supported, with partner collaboration.

BCC – any formative research? Theory of change?

Yes formative research with IPPT. But for BCC framework, desk review and other research that had been done. Did use former project HCP, looked at those former studies and strategies developed in Zambia, and DHS study. Was this information in your documents?

CSH also did formative research for national campaigns, which are foundation on which BCC Framework was laid. We have worked with CSH closely and utilized their studies in development of BCC Framework.

In Manza, Plan and JICA also want to establish listening groups. other stakeholders can buy into program, even if ZISSP not paying for air time, other stakeholders may do.

DHO can also buy air time on community radio.

Launching the RDL program May 31st and program starts running that weekend. Translation is finished for language to air first week of June (4 languages) – scripts are done in remaining 2, but haven't yet done the actual production of programs. Districts have committed to buying batteries for radios. Have also used CDS on memory sticks in some areas.

Where are Sr. Health Education Officers/Health Promotion Officers. Provincial level; Interview them.

What we have done beyond ZISSP districts is training zoned the country, E and S and L, CB NW and C together, Mu Lu N together. Did training in all 9 provinces, but not in all districts.

104 trainers includes drama, community radio stations, BCC Framework training and SMAGs, more males than females. At radio stations and in drama groups you find more males.

Any discussions on changing criteria or approach so more women can be empowered to participate?

In high school girls are part of drama groups, but when get married don't see themselves as having a role in drama groups. Women are there, but there are more men. Look for drama groups in field visits. Luanshya. Will share a list, they are also on training details.

Collaborative relationship with NMCC for BCC?

There is a health promotions officer at NMCC, also work with Research Principal. Interview these two government as well as ZISSP seconded staff at NMCC.

Child Health and Nutrition

Under five mortality rate reduced from 168 in 2002 to 119 per 1000 LB per 2007 DHS. IM rate from 95 to 70 per 1000 LB. Still these rates are among highest in world and sub region.

ZISSP goal: contribute to reducing childhood morbidity and mortality by CB for MOH MCD to coordinate, plan, implement and monitor health programs.

Looking at more focus on diarrhea and pneumonia (?)

Train HW in IMCI: CB of HW in IMCI so that at least one person at HF level is trained to manage sick children: Add question to PMO/DMO interview or HF checklist to assess this.

IMCI Strategic Plan - Includes focus on empowering mothers to seek health care for sick children.

Enhance Performance Assessment and TSS – 6 to 8 post training follow up visits – how well utilizing skills, how well incorporating ICMI at HF level, challenges in adapting ICMI services. Have integrated follow up support into existing PA and SS visits. Linkages with ZISSP supported CCAC teams to support for sustainability of acquired skills.

Extend RED and other innovative strategies: CB for HW and community volunteers through training and mentorship to improve access to and utilization of services. Has helped to empower community volunteers to participate bot in planning and mobilization and default registering for immunization and other child health services. Ask about this in FGDS.

Strengthen community child health registers and monitoring tools. Need to know what are weak areas to be strengthened. Did an analysis to identify key weak areas, community child health registers. Ask to see registers at HF visits.

Strengthen nutrition interventions and linkages at all levels: Strengthen integrated community level guidelines and training manuals; increase pool of national/provincial/district trainers through TOTs in IYCF; build capacity for health workers through training and mentorship in IYCF; build capacity for community volunteers in IYCD as well as HIV and nutrition.

Have looked at 3 districts in NP Luapula, XX XX, other partners with nutrition interventions. Selected Chienge no other partners there. Lufanyama and Masaiti including Luanshwa have received this CB, in SP Siinazongwe and in WP XX. More than 20 districts that have received this CB support.

Trained HW who supervise community volunteers for nutrition. Meet with nutrition volunteers. They hold community meetings where sensitize chiefs in community who take part in availing food, ensure that mothers take their children for growth monitoring. Have seen good support from community leadership in two districts in particular (not where we are going).

HIV and nutrition has been a critical intervention; a lot of mixed messaging concerning feeding, mother's choice affected by other family members. Added a component to strengthen counseling skills of volunteers on HIV and nutrition.

KBs: MCD MOH training institutions (how?)

Major Activities and CB:

Nutrition:

Assisted the National Food and Nutrition Commission to develop 8 policy briefs for stakeholders to facilitated implementation of First 1000 Most Critical Days – maternity policy and…

Developed Maternal and Adolescent Nutrition Guidelines for HWs

Helped NFNC to form 5 multi sector coordination committees for improved coordination in collaboration with NFNC (Mins of H, Ed, CD/MCH, Agric, and Local Govt and Housing) address this in coordination evaluation question. Interview whom?

Supported development of strategic plan WHERE? Relationship between committees and SP?

Assessed 25 HF in 5 D on BFHI – results: (see AR 2012)

Trained HW in IYCF (50/50 gender balance); trained community volunteers in C-IYCF and CBGMP (also gender balance – Initiative of ZISSP to combine these two training packages – ask more about this); trained HW (gender balance) in nutrition and HIV. Did ZISSP actually train or provide financial support for trainings? Add to training questions.

EPI:

Situation analysis of RED strategy in 40 HF in 14 d to decide where to focus efforts, was a MOH priority.

Reviewed and updated training and monitoring tools for RED strategy

Oriented OJT 60 provincial trainers in 20 districts in RED strategy

Trained 259 HW in RED strategy out of which 50% received mentorship (??) WHY ONLY 50%

Linked with PMTCT initiative how at community level?

Have seen immunization dropout rates reducing as a result of active roles of defaulter tracing who are the community volunteers.

Are immunization volunteers same as SMAG volunteers?

Ask HC about reduction of dropout rates.

IMCI:

Strengthened the Newborn Care Guidelines and Scale up Framework; pre service: in service: trained nurse tutors and clinical instructors from 12 nurse training institutions as trainers in IMCI using the IMCI Computerized Adaptation and Training Tool (ICATT); trained HW in IMCI in 18 districts.

ICATT – adopted how for ZISSP?

Now an 8 day training.

Is ZISSP training directly or supporting MOH to train?

Mushrooming of private training institutions, especially nurse training institutions, need to standardize this tool as part of their training curriculum. What is ZISSP Plan to do this in remaining project period?

Self-paced training. Hope that with other donors who can pay for computers for schools, each student can complete this training. Review this training model online. Useful tool for people who cannot leave their desk, including people in private sector.

Challenge to retain female HW in rural areas. So slight gender imbalance in IMCI trainings for HWs.

In terms of improving case management practices in HFs, ORT corner and corner: opportunity to reinforce messages with mothers. This is an area in follow up visits that is documented as a weakness. Diarrhea seems to be re-emerging as an area of emphasis for ZISSP and other partners.

There are opportunities to add new ICMI elements and messages to corners where they exist and build linkages to community resources.

KP: included NFNC, WHO/UNICEF, CARE, SAVE, PATH. Interview them in field visits?

Questions:

What is ZISSP trying to do to and beyond qualifying BFHs? To qualify, need to avail training, fills gaps like materials, policies, messaging, etc. Once HFs have been upgraded, who will create demand so that mothers bring babies to HFs? There is NFNC BCC team to do this.

ZISSP has come up with 10 steps for successful BF poster and fliers distributed to HFs and surrounding communities by ZISSP volunteers to create demand and reinforce standards. BFHI is not meant to be a HF because now it is BF, it links up with institutional deliveries, idea is to ensure that if baby is born there, HF is able to address early initiation of BF, exclusive BF, (review criteria), rooming, keep baby next to mother so can BF at any idea. This initiative was adopted by Zambia many years back, so if HF was assessed, where there gaps, they are addressed until HF qualifies. Like an accreditation process, but over the years, accreditation standards and gains were lost. So idea was to first do assessment for current status, supported by ZISSP. This was in plan for MOH to go back and reassess. Based on findings now MOH together with partners including ZISSP, will look at strategies to revamp HF BF status.

Report conducted end of 2011 and report in 2012. Where are things now? Next step is develop the strategy. An idea for SS, mandate is to work with GRZ partners to help them have evidence to address needs and gaps.

Do community nutrition volunteers do cooking demonstrations or counsel on how to optimize nutritional content of local available food? Are nutrition volunteers different from SMAG volunteers?

IMCI: ICATT – adopted how for ZISSP? Add to training questions

Nutrition volunteers are part of SMAGs. As part of GM they identify children who need more intense interventions, they are trained to prepare local food and get into feeding sessions. Will follow up specific mothers to do community cooking demonstration. What strategies are proving most effective?

Schedule follow up conversation about this.

Volunteers do follow other up in households, ensure that they report for weighing sessions to see if there are improvements. How does this link with NACS and intense feeding programs for malnourished children?

Request copies of red strategy monitoring tools.

What monitoring is happening at community level (broad question)

Where we have greatest need for monitoring is for nutrition from HFs.

Training starts with HWs, they select community volunteers to then undergone training for them, for skills reinforcement they go in turns

Opportunities for HWs to go t communities and assist them during GM, have noticed that under 5 registers at community HF are weakest in terms of data and updated info. Do volunteers enter data in the hf registers?

SMAG registers and UNDER 5 registers are different. There are several registers.

Do HWs have transport for community monitoring? vehicle? Fuel? Time? D supposed to provide transport or fuel; could mentoring teams play a role in supportive supervision for community volunteers?

NHC is an important structure to be general overseer of community volunteers. Ask NHCS if they see this as part of their role and if they do this. if so how and where and when and to what degree?

Given new CHAs, this is an opportunity to ensure that they are supported to provide technical oversight for community volunteers. They are given bicycles for transport.

More about formal relationship between CHAs who are new and cadres of volunteers, some of who have been in place for a long time. This challenge goes beyond ZISSP, issue of ensuring that community volunteers provide quality services. Intended supervisors are HWs at HC level; if you are lucky you will find and EHT, clinical officer and nurse. But in more rural HFs you will find one or two, no time to supervise. To extent that program like ZISSP can assist to improve linkages? Systems? Supervisory trainings? Whether that support translates into their capacity to do the tasks is another question since capacity is not the only issue.

Beauty of this program is that we are working within the structures of MOH. We do recognize need to ensure that first you have the tools, capacity of HW staff, not only skills but also so availability.

But can't place additional HR personnel for this role. It's a work in progress.

5th orientation with ZISSP April 15, 2013

Malaria:

Malaria team: Brian Shiba, malaria TL: Patrick Jewe, M&E malaria; Justin Chongo Logistics Adviser, Charles Nyandu, Procurement Manager for AIRS; Dayton Makusa IRS Manager; Musapa Mulenga, Entomologist; Benjamin Winters, with Akros – active case surveillance protocol Lusaka District and active infection protocol and M&E component of IRS, and entomological surveillance. Matthew Burns in field now.

Malaria still main public health challenge in Z, leading cause of M&M, affects mostly young children under 5 and pregnant women. Main priority in both national health stratetic plan and national malaria strategic plan.

Key Strategies for ZISSP:

Support IRS in 20 districts (previously3 5 up to Dec 2011)

Malaria prevention and case management with emphasis on children under 5 and pregnant women

Active infection detection in Lusaka district

IEC to support IRS and intermittent preventive therapy of malaria in pregnancy (IPTp)

IRS:

Conducted in 20PMI supported districts plus …"all districts"?

See slides for details.

Requires strict environmental compliance, managing insecticides and insecticide resistance.

Want to ensure that at least 90% of malaria patients receive prompt effective diagnosis and treatment according to current guidelines by 2014

At least 90% of all pregnant women should receive IPT by 2014

All case should be confirmed.

IEC: community sensitization to improve IPTp uptake, improve national ACT uptake, other.

Artesimen Combination Therapy

Key Activities:

Trained 5,457 to deliver IRS (both operator sand supervisors)Trained 531 trainers for IRS sprayers.

Developed team of master trainers/national facilitators to offer TSS.

Trained 4,926 spray operators under cascade trainings (?).

Distribution of IRS commodities: insecticides and personal protection equipment to IRS districts.

Safe disposal of insecticide waster

Enumeration of household structures

Developed SOPs for IRS commodities aimed at enhancing accountability and tracking of commodities

Supported TWGs to provide technical guidance to NMCC: IRS, Insecticide Resistance Tech Advisory Committee Malaria Case Management, Malaria M&E.

Routine entomological monitoring and resistance studies in selected districts – detected resistance to DDT, pyrethroids, and carbamates in some places. Map that shows southern

Africa region and recommendations; Zambia recommended for organophosphates, more expensive but only have to spray once.

Provided capacity to collect entomological data in 20 districts

Trained 54 EHTs in entomological monitoring and resistance studies, created 6 sentinel sites for investigations, maintained national entomology lab and insectary, including Lusaka and Kitwe.

Introduced malaria guidelines as source of reference material to health workers

Conducted Malaria in Pregnancy (MIP) assessment to understand factor that facilitate and inhibit the timely use of IPTp inZambia: found that only 48% of health providers were orientated to FANC; trained 4533 against a life of project target of 1,650, representing 26% achievement

Implemented use of organophosphates in 3 provinces.

Improved community health volunteers skills in community health care management: trained 622 community health volunteers FOR ICCM.

Established malaria active infection detection in Lusaka district: visited more than 1,500 households, tested more than 5,200 people, recorded 1.6% positive rate in participating clinics, handed over 5 clinics to Lusaka DHO (what is involved in handover? Any ongoing support after handover?)

Key partners: MOH MCD PMO DMO private companies mines and sugar, local authorities, Tropical Diseases Research Centre (TDRC), Malaria Institute – Macha, Malaria Control and Evaluation Partnership in Africa (MACEPA), based at NMCC. What is CDC doing with malaria in Zambia?

From malaria indicator survey 2006, 2008, 2010, led to active infection detection activities in Lusaka, incidence so low that Lusaka was dropped off? Showed that overall incidence going down, but still high areas. CDC doing a lot in malaria, too. Entomology for example. Have a doctor from CDC here to work with Musapa to work on entomological resistance.

Another person also doing technical backstopping Kathryn Tan with CDC.

Malaria is mostly found in eastern part of country, divided right down middle. On western side attempting to maintain gains. So spraying focused on eastern side.

ZISSP supported training of operators, supervisors, distribution of commodities, overall planning, monitoring and supervision. Gov, WB and GF funded other component of implementation and operational costs. Even in PMI supported districts, that was the approach.

Specific selection of 20 districts was from director of public health and research who suggested area of high incidence where districts are contiguous, benefit from transport efficiency, and result more observable than across scattered districts.

Given that less than 2 years remaining, what's the plan after 2014? This is a costly program, unlikely that gov will take it over. Last year gov decided to spray in all 72 districts, but could not for various reasons, main one being funding limitations. ZISSP did cover all districts

committed to, gov not able to, didn't procure supplies on time even with donor support. Last year was WB's last year to fund spraying.

For goal of receiving IPTi, goal is to receive at least 2 doses.

How's the RDT supply? Intermittent. Good except fluctuations in 2012 latter part of year, fluctuations in distribution, starting with November supply has been erratic. Big challenges.

How long before mosquitoes become resistant to organophosphates? Mosquitoes sometimes already develop resistance even before a chemical is used for spraying, maybe developing because of use as pesticides. Here try to select chemicals where mosquitoes are still susceptible and then rotate them.

What's relationship between long life nets (insecticides) and spraying insecticides?

Are people supposed to pay fee for house to be paid? This is with private sector, for our program don't pay anything.

In Lusaka there is a fee paying spraying program; yes, people have been going to households asking for fee to spray, this is a private enterprise. Not basically for malaria. It's for other vectors. This is extermination service, but is supported by Lusaka DHMT. (verify?)

CDC doc: this should be illegal. Insecticide resistance management groups should be monitoring use of correct chemicals, these people are not authorized to sue whatever they are using and could be creating resistance problems. This should be illegal. Long ago, a control scenario was run in Zambia and look at a fee for service for IRS, thinking that might add to sustainability by cycling through private markets. They found it didn't work and recommended against it. Don't tie baseline PH interventions for malaria to a fee for service model.

Has been discussed with private sector in past, although no decision was made as to how asking people to pay could work. Will have people who cannot afford to pay and they will be left out of spraying.

Wont' be complete coverage, won't be effective if leaves out people who can't pay.

Primary concern for Z's overall malaria management strategy is probably targeting and increased focalization within that targeting. We have good EPI data to support lack of IRS in Lusaka district, positively rate and overall prevalence rates are low enough to use more focalized response there.

We need to assist gov to recognize data points and choose not to spray where not needed.

any other mechanisms that try to link up more revenue flows from IRS activities, will be a problem.

ZISSP will try to push proper insecticide distribution and assist with choice to spray or not to spray, this can same millions of dollars over a 5 year period. Part of rationale for increased case detection; if you increase quality and timeliness of your data flows, have a better framework from which to assess which intervention makes sense. This is good support to government.

Not just Lusaka district the strategy of jumping from all districts all communities rather than setting priorities and costing the focalization is a big barrier to sustainability.

Who is F for CCM or ICCM on team? FANC and ICCM and CCM don't have focal persons, so currently fall under the Team Leader. Used to be that malaria team leader was clinician, now not the case, left about 4 months ago. Had the position posted to hire another clinician for CCM in particular. Didn't have success yet. Going to re-advertise looking for a Clinical Officer. Acute shortage of doctors. Market for doctors is problem in Zambia, most work in public sector, as USG programs not allowed to recruit from public sector. In the field must supervise medical doctors, so difficult to hire a CO or nurse to supervise them. This is a key difficulty ZISSP ha faced in filling clinical care specialist positions with non-doctors, since they supervise doctors. Big challenge for ZISSP in filling vacancies.

CCSs in province are spending a lot of time to work with malaria.

Could you achieve your project malaria objectives just through the CCSs rather than attempt to have a central clinical officer for ICCM, CCM, FANC?

A lot of what this person does here at central level is organize trainings, not conducting the trainings. Think we do need someone at central level but may need to be more flexible about whether person is a doctor. Get this JD?

This is exactly what we have been discussing, someone who can coordinate the FANC, ICCM, CCM activities at central level, maybe a training specialist/clinician? Then the CCSs who are doctors can handle the supervision aspect.

During 1st quarter, after team leader left, didn't have somebody to coordinate the CCM trainings, in working together with NMCC, they saw no reason why we should struggle to get someone to do this, they said a more sustainable solution might be to work within existing structures, and they chose to coordinate the activity themselves. Maybe one of the first things to turn over? They coordinated, they used doctors from provinces for trainings?

What was ZISSP teams involvement in MIS? Involved in planning aspect, training of participants, monitoring and supervision in the field; one of collaborating partners, not the lead. We had specific roles: procurement, funded part of transport and supplies; provided TS to train enumerators as well as lab techs and nurses collecting and entering data; provided monitoring and supervision support.

Next one is 2015, so ZISSP's mechanism will be over. But will start planning in 2014? Primary support partner MACEPA may or may not choose to provide support going forward. Talk with John Miller about that.

What will eventually become Zambia's malaria database? As data flows increase, the need for a sample survey becomes less and less important. MACEPA is wondering whether future MISs are a good investment.

Sustainability: an area where malaria team has made a good mark. When we closed out previous program, HSSP, we were given 8 months cost extension to continue spraying until program was put in place, reason was that there wasn't sufficient capacity built for continuity. One role of HSSP and now ZISSP is to build capacity of NMCC as well as at P and D level so that IRS program be implemented smoothly. When ZISSP came on board, we began strengthening all levels with big focus on P and levels. AT P level do have chief and officers and master trainers, and supervisors at D level. When training is organized,

would see these ZISSP guys doing the trainings, now the master trainers are doing with TS from ZISSP seconded staff (is this built in as QA?)

When NMCC asks for training support, we refer the now to these gov trainers who are now in place.

We talked briefly about ICCM; ZISSP's role has been to train supervisors from HCs in supported districts. We train HWs and community health workers/CHWs, we train them in CCM, challenge is to see whether and how they are implementing. And ensure that focus is on malaria, diarrhea, pneumonia. HCs receive commodities through supply chain, problem has been stock outs, if you look at what is contained in the kits, we are told that 5,000 amoxycillin is for catchment area and CHW is supposed to get supplies, so there are frequent stock outs, same with RDTs. Do not have them at center, so community is affected.

Protocols for ICCM, who developed? Using WHO? Yes. Supervision and monitoring tools were developed with stakeholders together, ZISSP participated. SAVE the Child guidelines?

There are efforts to make a decision tree for clinicians to give an alternative to what would be called malaria symptoms. CDC is looking for more specific framework for Zambia. This is IMCI. Would this be under purview of CCS or CHC? CHCs not medical doctors. But have public health background, have community experience.

Is there direct relationship between NCMM and health promotions team regarding malaria? Do you interact with health promotions office at NMCC? Yes.

Performance Monitoring and Evaluation Plan (PMEP) –

ZISSP has 2 types of indicators:
1. COP, IIP, MOP indicators, quantitative

2. Program Performance Indicators (PPIs) both quantitative and qualitative

Data collection: mentorship forms adopted from MOH, training registers, and HMIS: Vit A and DPT3.

COP, IIP, MOP Indicators:

HCWs that complete in service training program: 4 areas: clinical care, HRH, MS, BCC

new HCWs who graduate from pre service training institution (CHAs)

people trained in FP and RH: HW (nurse tutors/nurses) and CBDs

people in trained in MNH: EmONC (health workers); SMAG master trainings, SMAG volunteers

people trained in child health: HW (ICMI), IYCD, RED)

community health volunteers (Community IYCF, C-ICMC)

children who received DPT3 vaccine by 12 months, and % of children who received DPT3 vaccine by 12 months, %age difficult because of variance in denominator data, to get this must do randomized cluster survey; these indicators came during pre-proposal period.

Reason these indicators persist is because USAID has several indicators to report to DC and this is one of the standards. They recognize that ZISSP can't influence ….This is problematic; ZISSP cannot accurately report the percentage.

DPT3 data hasn't yet been collected for the 2012 DHS.??

Not something ZISSP is making a major contribution to with our resources; just a standard indicator that falls under child health globally.

In indicator narrative the reports clearly define the limitation for this indicator. CHECK THIS.

children under 5 who received Vit A

people trained to deliver IRS/supervisors and spray operators

houses sprayed, # houses targeted for spraying, # HW trained in IPTp

When you go to enumerate you can enumerate more than what you are going to target. Based on several things: may enumerate whole district, but may only decide to target hot spots, will be smaller than enumeration of whole area.

When you enumerate you count the # of houses actually there targeted vs. actual. It does happen in a few instances where targets were given based on assumptions about population and # of people in household, before district is enumerated. Then the enumeration gives actual figures. District is advised of difference. Do readjust targets based on actual data Do adjustments flow into reports? May be more or less households than you originally thought. Useful to report when you exceed targets.

Real issue is seeing whether houses you sprayed are the ones that you targeted. During PMI commodity audit last year, became aware that other places were also sprayed to reach the number. If refusals mean that you aren't reaching the original targeted households….interrupted. Data includes # of refusals and reasons. Is this linked with IEC OR BCC campaigns to address refusal reasons?

people trained in malaria case management

Volatility in the denominator. May not reflect intended households, usefulness of indicator is brought into question.

If DHMT doesn't pay allowances for sprayers to go too far, they won't go to targeted areas, sprayers will go to other areas in same catchment area but not so far. So now trying to hire sprayers from these communities so sprayers from far away don't have to go there and camp. Seems to be working well. District supports this strategy.

Instances where started with certain district, then politically it was divided, so changed spray target areas? Yes, had to go into new districts because of re mapping? Mafinga became Soka or vice versa? When training was happening, had to be split. From operations point of view, still view them as one district.

Have some houses that need to be sprayed once a year, others twice a year. In phase 1, count them as one. In phase 2, will split them. What %age have to be sprayed twice? Used the carbamate in 2 provinces, N and Machinga. Only there must be sprayed twice -13 districts. They call this phase 2.

Program Indicators- get this slide.

See slides. These are systems strengthening indicators.

# of improvements to polices etc., -that MOH adopts, implements, or institutionalizes with USG support. How do you measure improvement? Are you distinguishing between adopting, implementing, institutionalizing? In indicator narrative, we have specific definitions for every term used. Although initially put under program, got from the XXX people, not required to report on this. Way

PRODUCTION; # of policies, etc that are developed, reviewed, signed/approved, published, and/or disseminated with ZISSP support.

USAGE: # of program manuals, guidelines, protocols or curricula that are available and IN USE FOR 5 technical areas and for cross cutting topics (HRH, QI).

Example: planning handbooks are at various levels, so we count each one independently.

With these indicators, the emphasis is on qualitative information on our contribution, the improvements, and stage of improvements or progress or status.

Example, clinical mentoring guidelines are being used at district level.

Those things you promised USAID you are going to do are the key indicators. Are these proxy indicators?

We have mandatory and optional indicators: these are the ones that Zambia has selected to report to DC.

How can we get a breakout of which are mandatory and which are optional?

These being presented are internal, are ZISSP's.

We are counting a contribution when adoption or implementation or institutionalization happens.

These are useful SS milestones.

The clinical mentoring guidelines and training materials rest on foundation of clinical mentoring system that was established under HSSP especially to support the HIV ART program. Everyone recognized not effective to mentor only under one technical domain; ZISSP broadened the mentoring focus to other clinical areas. HSSP developed the model to focus on HIV, and there were different partner tools. Partners had developed in HSSP era different tools for ART mentoring. One effort was to harmonize donor funded programs, do it through one common mechanism, the clinical care team at D Nad P levels rather than having donor funded project teams going out to do clinical mentoring.

We are somewhere along spectrum toward implementation. Can see evidence that are clinical care team sin districts now evidence that QI teams are being formed. Another one of areas of improvement.

At what point tried to measure # of clinical care teams formed with support from ZISSP not being tracked? Trying to track existing or functioning teams, since had already started under HSSP. Sold this idea to gov, was adopted by gov before HSSP ended.

Would be good for evaluation to know how many teams ZISSP helped to form.

The above indicators relate to Task One.

Proportion of target districts that monitor district action plans, revise activities and budgets quarterly to reflect performance and resources. Can we develop the report within these indicators?

Proportion of MLA participants enrolled for 5 months that complete all 4 training sessions. Attrition rate? Can make up a missed module later on. There have also been specific make up sessions. This program was designed to have short, quarterly classroom sessions with mentorship in between. Scattering training over year has its own set of problems – mobility, what else? Follow up with this during training conversation.

Proportion of districts with trained CCTs that have fully or partially funded Clinical Care Teams (CCTs) (AIM IS ONE PER DISTRICT). Within CCT there should be child health expert, EmONC expert, etc. a resource pool. Have criteria for team members.

Proportion of ZISSP target districts with district health action plans that include any interventions included in the Adolescent Reproductive Health Strategy.

?? Form is filled out when district is establishing the team. Are you looking at composition of team or just at whether team has sufficient members? What constitutes functional? How likely is ti that you have functioning experts in all technical domains due to attrition? Can teams remain stable over time due to turnover, etc. Who can fill in?

Started implementing WHAT? beginning of 2012; started using it in draft form.

# of HCACs that have been trained in community health planning, have prioritized community health issues in community action plans and implement at least 2 of prioritized activities during course of the year. (Add these 3 questions to HCAC interviews?) Have HCAC members been trained in community health planning? Are community action plans in place? If so, have at least 2 of the prioritized activities been implemented? Can measure this at end of 2013?

The thing to know is that the planning cycle for activities that could have taken place in 2012 happened from June 2011. Would have to look in data set for people who are trained, HCs where you would expect it to have happened are those who were trained in planning before planning cycle in 2012. Get trained, then hold meetings to make plans. So number will be small. Expect that number will go up in 2013 and by end of project. Could check in some HF that they have made a plan, have some priority areas, may have started to work on them. These are not stand alone plans, these activities integrated into the HF plan.

Community plans fit into health center plans, which fit into the consolidated district plan. It will be revealed in the District Action Plan. KP thinks the HF is place to find the documents.

Should be able to see planning they did at each HF. The community activities in the HC plan.

Proportion of target facilities with trained SMAGs.

# of private companies and/or NGOs that have been engaged in HIV/AIDS, FP, malaria, MNCH or nutrition services through PPP and any other types of partnerships.

We have received a list of all of their indicators, both mandatory and additional internal.

Need to clarify which indicators have been revised and clarify how to report.

Primary difference between two sets of indicators is the time period.

For MLA proved difficult to get all 4 sessions done in just one year.

Paul: there are more indicators in your original PMEP. Where are they?

First year of Z mission management was completely different, and collective personality of mission changed in second year. New director put more stock in importance of reporting indicators. Her concept is revise indicators where needed to reflect changes in environment. Her importance is to reach targets.

ZISSP has revised the PMEP 3 times since project began. Our indicators in the revised workplan submitted to USAID is inconsistent with these indicators, so have sent the evaluation matrix to ZISSP to revise.

Group Meeting with ZISSP Clinical Care Specialists

May 27, 2013 Interviewers: Beatrice and Jean

- The overall project is supposed to have 9 CCS but currently only 7 positions are filled.
- Present in the meeting were CCS from Copperbelt, Eastern, Northern, Southern and North Western provinces
- Absent from the meeting were CCS from Central and Lusaka provinces

Quality Improvement

QI is done in the Core clinical technical areas e.g. IMCI, maternal health, child health and EmONC

- **QI process:** When a problem is raised during the Performance Assessments, e.g. when pregnant women are not tasted for syphilis- the QI committee is informed and a visit is made. Or if it's due to limited capacity, then mentorship is provided. If it is an issue with Medical Stores Logistics, lobbying is done. If an order of RPR kits does

not show up, the provincial CCS should be tasked to follow – up with the provincial office. CCS have had discussions with Pharmacists who are part of the QI team. During QI, registers are checked, the team goes through the data to check for things like confirmed and clinical malaria cases. The district gives a weekly incidence report such as RDT. Right now there is no Nevirapine for PMTCT. The QI teams also go round conducting TSS on data use and some districts are now being responsive. The have also started evaluating the MOH selected QI indicators. QI indicators do not include family planning.

- **CCS role in RED strategy roll out:** RED Strategy training is conducted by Mary Kaoma the ZISSP MNCH specialist based at national level. CCS assist with this training. ZISSP is not fully involved in routine immunization, but provide planning and financial support during child health week.

- **Regarding outbreaks of vaccine preventable diseases:** Yes – Measles and was attributed to breakdown in cold chain especially in valley districts due to high temperatures.

- **Routine Vitamin A:** Trend is to wait for child health week and this is challenge.

- **Data interpretation and use:** An example was given about Gwembe district where they realized that they were not meeting their fully immunized targets despite scaling up outreach activities. When CCS visited, she checked their registers and discovered that BCG vaccine was derailing the fully immunized figure because HWs waited for 10 children to open the vial.

- **Mentorship:** This is provided but it needs to have enough skilled mentors to bring it to scale, and cover all districts in the province.

- **Model sites:** MOH in collaboration with ZISSP selected some sites in ZISSP districts but found that some ZISSP-supported facilities had no qualified staff and this led to ZISSP taking on facilities in non ZISSP districts.

- **MCH:** Losing a lot of mother baby pairs due to weak community/facility links. CCS - will collaborate with CHCs who support SMAGS, lay counselors and UNICEF Mwana program on the Copperbelt. BU facilitators are tracking their facilities.

- **Issue of training/verses supplies:** ZISSP is compelled to training even in absence of equipment and supplies for example, IMCI is about referring a child who needs it even if there is zinc, or other drugs- so training is justifiable- at least some HW will assess and refer

- The CCS mentioned they had done a needs assessment but we were not sure which needs assessment was conducted.

- **Collaboration:** QI training done at provincial level, Mansa for example- pushed in own funding to train 31 HWs- cost sharing, developed QI training package in collaboration with CDC, MOH visit to SMAG districts and conduct training together, PHO- CO funding some activities such as payment for allowances, worked closely with CIDRZ on development of Misoprostal guidelines

- **Bi – annual PA**: Not yet given guidelines- so has not done but sites identified

- **Have you participated in site accreditation:** -Yes site preparation before accreditation – was in last year workplan but not done

- ZMLA: Is a good training - need to increase number trained to include H/F managers. MOH should take it into pre-service.

- **Challenges:** - They have had limited financial capacity, most guidelines started being developed in 2011

Consultations with Zambia Integrated Systems Strengthening Programme (ZISSP) Community Specialists- Courtyard Hotel Lusaka
27th May, 2013

The ZISSP personnel were attending the occasional consultative meetings in Lusaka. Present were all the Community Specialists except for the one from Western Province who did not attend and for Muchinga the newest province that came into being after the ZISSP programme started and has no specialist attached to the provincial health office.

The work of the Community Specialists cuts across many of the ZISSP interventions. However, it seems most of their work comes under the leadership of the BCC Advisor and the Social Mobilisation Advisor.

Some achievements by the community Specialists

- Under the guidance of ZISSP Advisor for Family Planning, Community Based Distributors of family planning methods were trained in Central, Copperbelt, Eastern, Luapula, Lusaka, Southern, Northern and North-Western Provinces.
- After their training supported by ZISSP the Community Health Assistants work closely with the ZISSP seconded Community Health Specialists.
- Grants were awarded to a number of community based organizations to scale-up ZISSP interventions. Uses for the grants includes:
    1. Community sensitization for persons living with HIV/AIDS
    2. Reproductive health including family planning
    3. Health seeking behaviours relating to the ZISSP defined high impact interventions
    4. Community planning processes
    5. BCC for reproductive health
    6. Training SMAG members
    7. Peer education campaigns

8. Integrated health education programme

Organisations awarded the grants include:

1. NZP+ Mwinilunga Chapter
2. Centre for Infectious Disease Control in Zambia (CIDRZ)
3. Group Focus Consultations in Mansa
4. Thandizani in Lundazi
5. Community Integrated Health Education in Luanshya

Despite the Grantees having started implementing their projects later than planned, the Community Specialists were confident that the Grant supported activities will be finished before the ZISSP programme comes to an end.

- Radio Distance learning broadcasts will be started this month. The official launch is on Thursday 30th May, 2013.

Community Health Toolkit

This is a major source of guidance for the work of the Community Specialists. The tools in it were developed at the national level with inputs from the Community Health Specialists. It includes guidance manuals on:

1. Community Planning including Gender Guidelines
2. BCC Strategies

The Trainers of Trainers have been trained in the use of the toolkit. Those trained were the District Planners and the Health Promotion Specialists. Starting in June, these would train people from the communities. To start with 30 participants per health facility will be trained. The objective is to train participants from 2 facilities per week until all the target facilities are covered.

Community Drama Groups

These are important for the BCC strategy. Two drama groups have been trained in North-Western Province, three in Mambwe in Eastern Province, two in Nyimba in Eastern Province and two in Mansa in Luapula Province – one per facility. In Southern Province, the Drama groups were trained in facilities to be covered by the Radio Distance Learning programme. That was also the case in Copperbelt Province.

Work with Private Organisations

They have gotten the Neighbourhood Health Committees to mobilise support from the private sector to support community initiated projects. In Copperbelt, one committee got a company to secure its health facilities by putting up a boundary wall. Others got roofing sheets to complete structures. Others got televisions which are useful for health education. In North-western Province, the drama groups trained by ZISSP have been hired by the mines for road shows financed by the mines social responsibility programmes.

Collecting Data in the Communities

This is not well coordinated. There are multiple tools used depending on who requires the data – usually the Donors of the programmes. The ministry of Health should do something and harmonise these tools the way it was done with the health facilities Health Management Information System (HMIS).

They have also proposed an inclusion of HMIS indicators that should be used with the Performance Assessment tool.

Successes of the Interventions of the Community Specialists

1. Neighbourhood Health Committees have been strengthened. They were there before the ZISSP Programme but in a passive state. Health facilities tended to plan for the communities but not anymore. District Health Offices now expect health facilities to engage the NHCs because among others, they are a useful resource for mitigating against the staff shortages from the huge volunteer programmes.
2. Relationships between health facilities and communities have been improved.
3. The strengthening of the community planning process has led to an increased sense of ownership of the health interventions by the communities.
4. The NHCs are now better organised. They prepare minutes for their meetings, meet as scheduled and develop plans for inclusion in the facility plans.
5. NHCs are now aware that they should have access to funding from the health facility. They are also aware that they have a full say in the planning and management of the health facilities. With this awareness, communities have caused poorly performing health facilities staff and those who have misapplied funds meant for activities in the communities plans to be removed.

Management Specialists Group Interview Summary Notes from May 27, 2013

Q1 – Officers responsible for each of the following areas:

a) **Community Health Coordinators** coordinate the following programmes
   - **C-IMCI** using mechanisms such as SMAGS and Community Health Workers

b) **Clinical Care Specialists** are responsible for the following programmes
   - **F-IMCI**
   - Maternal Health/EmONC
   - Malaria case management (down to community level)

c) **Management Specialists** are responsible for the following programmes
   - Long-term Family Planning (coordinated logistically at provincial level but programmatically from the central level)

d) **Centrally managed programs**
   - Spraying (sometimes provincial staff do not even know the team is in the province)
   - General Coordination – each province has a provincial coordinator from amongst the three seconded staff. This is an additional role to coordinate administrative task among the three staff members and to act as an anchor (in the province) for those activities that none of the staff are directly responsible. Appointment to this position is done on a one year rotational-basis.

Q2 – Specific roles and tasks for seconded staff

[this question was deferred to the clinical care specialists]

Q3 – Role in QI

In discussing this question, there was apparent confusion in term of how each MS understood QI. One group said it was the responsibility of CCS while another said they were involved in one way or the other:

a) Those who said MSs are not responsible stated that QI has been equated to clinical mentorship and that is where every starts and ends. Clinical mentorship has been a preserve of clinical teams with very little involvement of the MSs
b) On the other hand some MSs felt they were involved in some QI through QI/Performance Improvement programme they have been running through the EDU course but emphasized that this was not mapped in any way to the mentorship that the clinical teams were doing. Although the MSs team is supposed to provide M&E support to the clinical team – this is not happening.
c) On the indicators for QI, none of the MSs were aware of the bouquet of indicators selected for QI

Q4 – Private Sector Support

Support to the private sector does not go beyond coordination of activities that require the involvement of the private sectors. Some examples cited include:

a) Resource mobilization for inter/national days such World AIDS day and Immunization Days
b) Epidemic Preparedness – this is done through the office of the provincial medical officer and the provincial permanent secretary

Note: The team could not bring out examples of how they have assisted in bring the private sector to become active player is service delivery or whether any private facility has received support from them in a similar way as the public facilities.

Q5 – Marginal Budgeting for Bottlenecks

a) All the Management Specialists have been trained as trainers
b) Participated in training Planners, District Health Information Officers, Senior Health Information Officers from Lusaka, Southern and Central provinces
c) This training was meant to orient district level staff on the redesigned approach to MBB to suit the district level and the roll-out was planned for mid-2014 but may not take place due to the realignment of the ministries. MCD requires preliminary capacity-building before they can get moved to MBB – The training manual is currently in the first draft.
d) On how this effects on the existing planning handbooks – the team was not sure whether they will be a need to revise the handbooks to accommodate the MBB.

Q7 – ZHWRS

- All the Management Specialists reported not to have a role to play in this as the programme is centrally controlled.

Q8 – ZMLA

Below are some of the weaknesses identified that need not be perpetuated:

a) Selection criteria – Lower level organs were not fully involved in identified positions that needed to be included in the initial training. This was controlled and coordinated from Lusaka. As a result some positions that were prescribed for inclusion in the training, were either not yet filled in or the staff member was not available for the training, some of these positions were filled up but so with people nearing retirement.
b) Although the course has done very well when it comes to classroom supervision, it was not the case when implementing case studies. This component was not funded and as such their value (important though they may be) has not yet been appreciated. The MSs have since started advocating for district to plan for this activity in this year's rolling plan.
c) ZISSP intends to train (GRZ) mentors to increase the pull of mentors at the local level as way of cultivating sustainability
d) NIPA should continue to run the course because of its added value that comes with accreditation and certification.
e) The ZMLA programme has had too many external consultants – the team feels this should be reduced to give chance to the programme to mature locally and save resource towards sustainability activities.

Q9 – Transitioning from MoH to MCD

a) Below are the activities that have been identified to be transition-ready:
   - Data Management – this has already happened through administrative transfer of district responsibilities to MCD.
   - Planning and Financial management – Even before the transfer, focus of capacity-building for the two components targeted district level staff. They have since shifted with the skills
b) Below are the activities that team identified as needing more thought and planning before transitioning:
   - Supervision – The role of the provincial office in its current form and mandate is not so clear as what support and to who the office is supposed to provide it.
   - Realignment Process – The Management Team felt, if they were given the mandate, they would provide support to the government in the whole realignment process. As it is now, there is no role that ZISSP is playing in this important activity

Q10 – Strongest Contributions by ZISSP

The Management Specialist Team identified the following as the strongest:

- ZMLA – strongly appreciate by many people that have gone through it, including traditional leaders
- Re-introduction of community involvement in planning. However when reminded that every year the national level set priorities that EVERYONE should adhere to, which in the real sense contradicts "bottom-up approach", the team defended themselves that it was always necessary to provide national guidance. When asked whether it was necessary to do that every year and not at the time each National Health Strategic Plan (NHSP) was release, it was clear that the team never thought about that. The current NHSP runs from 2011 to 2015 and apparently no dissemination of these priorities where done.
- Pre-planning review meetings and Pre-PA meetings: This was reported strongly supported through ZISSP and as such has assisted in identifying areas that need attention. The government has since started covering the full bill for these activities.

Q11 – Things that have not worked well

a) Although each province has positions for three seconded staff, synergy among them has not been established – they reported to be working in "silos".
b) Seconded staff have not fully imbedded into the government structures as they are always treated as donors due to a number of reasons, among them their conditions of services which are better than their counterparts

Q12 – Community-based HMIS

The provincial team was not aware that they had a role to play. They cited a few isolated local-level initiatives, which were not good enough to qualify for a "system"

Q15 – Stock outs

The team reported that this is not their core area – it depends on the local needs. They gave examples from Western Province. Proof of having supported that effort is pending

Q16 – Verifiable Indicators

The team reported that this has been discussed before but not consolidated. For now what they said they have is just a checklist – I am yet to receive it from Emily, their Team Leader.

Interview Questions for Ministry of Health (MOH), Ministry of Community Development, Mother and Child Health (MCD/MCH), and National Malaria Control Center (NMCC)

: Background information

Date:18 April, 2013_____ **Central Level:** MOH PH&R

Title of Respondent __Dr. Maxwell Bweupe_____ **Sex:** Male__X__ Female_____

Enumerators name:_____Beatrice, Paul, Deborah_____

SECTION 1. PROGRESS TOWARD RESULTS–Improving access to and utilization of FP, HIV/AIDS, malaria, MNCH and nutrition information and services in ZISPP target districts

Introduction: The evaluation team is looking at all layers of management and service delivery for which ZISSP has provided support: National, Provincial, District, Facility, Community. Purpose of MTE is to understand how far ZISSP has progressed, are there things that need to be adjusted before end of project, also what would be needed post ZISSP. We have a set of questions covering CB, HR, Coord, CO and G.

1.	Will you please identify specific changes, if any, in access to and/or utilization of family planning, HIV/AIDS, malaria, MNCH and nutrition information and services that have occurred in the districts where ZISSP has operated since 2010? First when you look at those program areas, service delivery areas, impossible to give attribution to a single agent - Because of this, therefore there is this. Because of ZISSP, therefore we have these changes. We all pull in the same direction, everyone contributes. Having said that, in Malaria we have made a lot of advances in terms of service delivery, indicators, even information gathering. Just finished the MIS, we know exactly where in Zambia (the 3 regions) we have highest transmission, middle, lowest rates. Found a 66% reduction in Morbidity and mortality, especially for most vulnerable, eg under 5, pregnant women. Colleagues at NMCC will give more details, but ZISSP has been part of this effort. Next thing is in terms of our initiatives for Maternal and Child Survival, there is a spectrum of high impact interventions. A lot of partners are involved. Promoting early ANC, safe motherhood, safe delivery, PNC, FP, for children anemia and immunizations, promotion of BF, and then IEC. Again, we are privileged to have FP?? for Saving Mothers Giving Life, of which ZISSP is member and has been key partner for EmONC, have helped drive agenda very much. What does that do for us? Targets mothers to keep them alive, have safe delivery, also helps us in trying to improve health of children. By their own nature, indicators for maternal survival are not something you can assess in 2 years. Takes minimum of 5 years or a decade to say we have really shifted. For anyone managing a maternal survival program, not fair to say what is impact in the space of 2 years. But there are things you can say, like processes and inputs, maybe are going to tell us that in 10 years' time we have moved. Some inputs from ZISSP: HR capacity, a lot of midwives, clinicians, and environmental health technicians that have been trained in BEmONC, newborn care as such, helping babies breathe, and CEmONC. Has included getting equipment, have helped us in provinces, getting to grips with equipment that has been brought in not only by ZISSP but also coordination of efforts – got equipment from DFID, JICA, able to do inventory to see where is greatest need, more intelligence on where to place equipment. In terms of nutrition, not too familiar about work done by ZISSP as such, haven't had my finger on nutrition. Doing more for maternal survival. For child health, we've been having routine immunizations but also have campaigns which we do twice annually. We have had successful campaigns every year for number of years, mostly formed TWGs, have them, which everyone's comparative advantage is there to see how they contribute to successful campaigns. Our colleagues are always around to offer technical contribution as well as deploy to regions when actually doing campaigns. We are doing what Ministry had interest in a long time ago; DHS surveys give you information for midterm to long term planning for sector. Always have lengthy meetings, go one for year and a half, take too long. ZISSP colleagues have been key in driving agenda forward for the DHS. For strategic planning purposes have also contributed to what we are able to do (ask elsewhere about use of mbb trainings for costed strategic planning). they have been involved in quite a lot of things, in strategic planning, program implementation, evaluations of what we do. in essence, for a 2 year program

	meant for systems strengthening, its' a fair contribution. When we look at those building blocks (is he referring to WHO building block?) team think about referring to each of these in report), building capacity, equipment, coordination, governance issues, to draw up policies and guidelines. He is not familiar with level of support for commodities. Have talked about Information systems, a strategic area of DHS. Z works with our colleagues in policy and planning for IS as such.
1.1	**Family planning:**
1.2	**HIV/AIDS:**
1.3	**Malaria:**

1.4	**Nutrition information**
1.5	**MCNH**
2.	Do you view them as positive and why?:
3.	Do you view them as negative and why?:
4.	In your view, what role has ZISSP had in bringing about these changes?
5.	What activities and approaches were most effective and why?
6.	What were least effective and why?
7.	**What in your view are the key challenges in improving utilization of these health services?** We sit in TWG: don't want to mention Z as such. Another example: JSI comes into country to strengthen procurement systems for pharmaceuticals, they are meant to work with line ministry with a view that a lasting impact is there. If they set up an office in nice big building and start doing their own system, when I ask procurement guy, he has no clue what they are doing, just knows drugs have arrived. What systems strengthening is that? Not saying ZISSP is in same line, but to a certain degree a lot of support that we get does end up leaning in that direction. (IPs who set up parallel systems rather than align with government) **What about seconded staff as strategy to prevent parallel systems?** Yes, had Bernard here for some time, does help to have physical presence, appreciate the challenges the Ministry faces day to day, also have a direct liaison, helps you transmit concerns. **We are looking at ZISSP having another 1.5 years to go; we have all these seconded staff provided to MOH in different directorates. What will happen at end of ZISSP; will MOH take on any of these positions?** For RH, we've had support with EmONC and newborn care having a person focusing specifically on that. From what I see now, do not see us employing someone when this position ends, in next year or so, due to treasury authority for a new post takes ages, and with realignment of laws with CD/MCH we might see that not necessary for MOH to employ someone. For this position, don't see that this will happen.
8.	**To what extent has the ZISSP project contributed to policies and guidelines?** Examples of guidelines and policies: key things we've been doing: RH policy, has taken long to finish, child health policy, countdown to MDGs. We do reviews, have got a Road Map for Safe Motherhood, we have a look to say we are doing

	countdown as we approach 2015. Have you spoken with Kamoto Ndeo? Yes. We received technical support from ZISSP for all. He values when partners sit with Zambian colleagues for Technical Support. ZISPP has also supported training in roll out of these policies.
9.1	**Family planning:**
9.2	**HIV/AIDS:**
9.3	**Malaria:**
9.4	**Nutrition information:**
9.5	**MCNH:**
9.	**Between now and end of 2014,what are most important issues that ZISSP needs to address in building capacity to improve access to/utilization of health services in target districts?** Am most interested in generation of locally based evidence and information. You come and help me train 200 people, fine, but I want to be able to look at data and say this is what we have been able to do. I would like lot of work in generation of evidence, in particular for me, if rest of year they helped us to do maternal death audits, I would be the happiest; would like to know why women are dying. **What from your perspective is the best evidence that SS has happened?** I would look at service for EmONC and newborn care. If we have done a good job in those areas. May not be nationwide. Service delivery in access to safe delivery.
10.	What can ZISSP do between now and end of 2014 to ensure that improvements in access to and utilization of health services will be sustained after the project ends?

What about ZISSP involvement in misoprostol guidelines?
The guidelines have been rolled out, have had some start stop problem because of question of handling of misoprostol. It has the potential for abuse. Some people offer resistance about how the supply is being safeguarded. Have had problems in Northern Province where provincial minister has been trying to chase people away. Haven't explored full potential.

SECTION 2. CAPACITY BUILDING – Progress to strengthen capacity of MOH/MCDMCH and NMCC staff at national, provincial, and district level to plan, design, implement, manage, monitor and evaluate health programs within each of the five program areas (1) HIV/AIDS, (2)malaria, (3)family planning, (4) maternal, newborn and child health (MNCH)and (5)nutrition)?

11.	**How does MOH/MCDMCH/MNCC define capacity building? Or how do you define capacity building?** CB in context of ZISSP would be more toward provincial and district service delivery level. In terms of exclusion of my level wouldn't' say that CB has been built in me. Not what they are tailored for. Not at HQ level. **What would be valuable for you?** People you have in ZISSP are my contemporaries and there is no advantage for me; maybe we can share ideas, but they are peers. Come and teach me Health
12.	In your view, how effective have ZISSP's capacity building activities been to:
12.1	*Strengthen capacity at national level to plan, manage, supervise and evaluate delivery of health services nationwide.* Please explain your answer and give examples.
12.2	*Improve management and technical skills to increase use of quality health services within target districts* .Please explain your answer and give examples.
12.3	***Improve community involvement in health (behaviors, planning, demand for service) in targeted areas.*** **Please explain your answer and give examples.** Reluctant to comment difficult to assess, you go, you organize meeting, people turn up, showing lasting effect is difficult. Can say we've built capacity at service delivery level in terms of HW trained and equipment provided, how that translates into change can't say.
13.	How if at all has ZISSP increased the involvement and leadership of women in health related activities at any or all levels (national, provincial, district, HF, community)?
14.	What is your perception of ZISSP seconded staff's role and value in building the capacity of GRZ counterparts to plan, design, implement, manage, monitor and evaluate health programs at the national, provincial and district levels?

15.	What could ZISSP do in the remaining project period (to end of 2014) to position the MOH/MCDMCH or NMCC to sustain capacities that have been built through its partnership with GRZ? **What role did seconded person play in building capacity?** Was more like program officer to lower middle management, so more to do with programming, having actual programs, tools, action plans, implementation, mentoring. Didn't have that position, so was an extra person, ab articulate and hard working person able to drive the agenda because he was around and could concentrate on area where capacity was strained. He went on leave, position
16.	What if anything, could ZISSP do to help MOH, MCDMCH and NMCC work collaboratively at national, provincial and district levels during remaining project period?

SECTION 3. HUMAN RESOURCES FOR HEALTH

17.	In what ways has ZISSP strengthened MOH/MCDMCH/NMCC capacity to attract and retain health workers in rural positions and areas?
18.	Do you think this will be sustained the after projects ends?
19.	How is ZISSP with GRZ measuring differences in quality of job performance and/or health services as a result of trainings it provides at provincial, district and HF levels?
20.	How does ZISSP with MoH/MCDMCH/NMCC measure whether having a broader pool of trainers and tutors in target provinces and districts leads to improved health services quality and utilization?

SECTION 4.COORDINATION AND INTEGRATION

21.	**In what ways has coordination and synergy of HIV/AIDS,MNCH, Nutrition, FP, and Malaria services in project target districts been strengthened by ZISSP, if at all?**

	Looking more at RH and HIV, they have had a strong presence in that, have been active in helping us draw up, previously having RH separate HIV separate, have been key member of TWG in having harmonizing of this and developing manuals together with UNFPA for integrated RH and HIV, even for programming, we have a much more integrated system now, where if a woman comes for issues of FP, HIV is also addressed, If woman comes for HIV issues, her FP and other concerns are also addressed. We have all moving in the same direction, they have contributed.

SECTION 5.COUNTRY OWNERSHIP

22.	**Can you give any examples of ways in which staff seconded by ZISSP to MOH or NMCC have built capacity of GRZ counterparts to plan, design, implement, manage, monitor and evaluate health programs at the national, provincial and district levels?** ZISSP is similar to FHI ZPTCII, which more or less operates within government Zambia government guidelines. In alignment. FHI ZPTC and ZISSP pay a lot of attention to looking at where host country is going and what they want to do, we have extremes of pepole who come and do basically next time you'll see them is when they want a letter of support for next 5 year funding, have tried very hard to align themselves to government priorities. We draw the instrument together and they help us to implement it works for both of us.
23.	Do you think this new capacity will be sustained after ZISSP ends?
24.	Why or why not?

SECTION 6. GENDER

27.	**In your view, has ZISSP influenced any increase in the consideration of gender integration in your annual work plans? Please explain your answer.** Doesn't' know. Has never discussed with ZISSP. Nobody goes out of their way to say we must address this. Don't want to say that women have equal opportunity already, but somehow it doesn't' come up. In all things we do, our decision making bodies there is equal representation. I take it for granted possibly.
28	In your view, has ZISSP influence the degree to which annual budgets at community, facility, district and provincial level incorporate gender issues? Please explain your answer.

Anything else you'd like to share with us?

I might have been a bit privileged in that years back, we were sequestered together, looking at institutions applying for this grant which ZISSP is implementing, most documents in terms of reference are quite detailed, don't know if time people have time to implement is adequate. To significantly impact a health system it might be a bit ambitious to say that we will do it in essentially 3.5 years. Because you are awarded, get yourselves organized, don't know you your boss is, normative, formative status now getting started, then must prepare reports because time is ending, policy up your image and get ready for new funding.

Instead of having whole project start stop start stop would prefer that there is a long period of implementation with more rigorous monitoring of performance and power to hire and fire individual people who are not performing. There is continuity in organization but if anyone is lagging behind they are easily gotten rid of.

People start looking for jobs when project is due to come to an end. Let institutional arrangements take on longer period of time, doesn't mean that same people whole team will remain. More rigorous internal assessment. But keep the institutional memory and institutional systems.

Thank you for your time and the information you have shared. Reiteration of how information will be used. Provide contact details in case interviewee has any questions after interview.

Interview with MOH Directorate Technical Support Services

Date:	April 17, 2013
Informant:	Dr. Mulega, Deputy Director
Ministry:	MOH
Directorate:	Technical Support Services
ZISSP focus areas:	Performance Assessment (PA) Review Tools
	Technical Support Service to address issues identified in PA Reviews
	Zambia Management and Leadership Academy
Interviewers:	Jean Capps ZISSP MTE Evaluation Team Leader
	Kumbutso Dzekedzeke, ZISSP MTE Evaluation Team Member

Technical Areas: This office is responsible for governance and systems in the provision of services by the MOH. These are crosscutting areas not specific to ZISSP interventions of interest MNCH, FP, HIV/AIDS, malaria, or nutrition. "We have oversight, but we don't directly implement programs."

The Technical Services Directorate is responsible for Pas. A closely related area of technical services-Quality Assurance falls under the Clinical care Directorate. PAs takes a multi-disciplinary approach and has been in use for about 5 years. They monitor a set of key MOH

indicators at multiple levels of the GRZ health system. PAs are done twice in a year in the first and last quarters.

His office looked at reviews of semi-annual performance reports and identified poor problem identification and poor project management skills as priority deficits. One way identifiesd to address this problem was the ZMLA. The ZMLA was started in 2010. Under the ZMLA, participants are trained in pairs of district-province and national level-province. They are exposed to concepts of management so that everyone in the districts, provinces and the national level are appreciate the need for cohesion when delivering services. The ZMLA courses are carried ou in the provinces. The province decides the time when the trainings will take place. Then a team of mentors from the Ministry of Health, BRITE and the National Institute for Public Administration travel to the province

PA is a multi-disciplinary approach. "PA gives us the chance to assess things from multiple levels." The district monitors health facilities under them; provinces monitor districts, MOH headquarters monitors provinces. Used as a supervision tool but also provides opportunity for capturing and sharing lessons learned and best practices. ZISSP assisted the TWG developing PA review tools. They are finished but not yet fully implemented because the districts are now under the Ministry of Community Development Mother and Child Health. **A modality for the two Ministries to work together to address the problems identified during the Pas is being developed. He feels they will be implemented before the ZISSP program ends.**

ZISSP helps take information from the PA reports and help develop technical support to address the issues that are identified in the reports. (Need more info on this). See more on ZMLA below. They teach technical support and health facilities have a self-assessment tool form. They review these forms and see if issues make it into action plans and whether action plans are completed. (Joint MOH and NIPA). This is used for developing mentorship.

ZMLA is operated out of this office. ZISSP (specifically BRITE) has done a great job and the training is really needed. Participants are located at the central MOH in Lusaka, and in provinces and districts. Too early to link PA report results directly with the ZMLA training because they haven't graduated yet. He has heard anecdotal feedback that the training "has them thinking of things they weren't aware of" or "we were never asked to do these things before". EGPAF and other programs have wanted to do similar things but they only wanted one program. ZMLA works closely with NIPA and in the long run, NIPA should eventually take this on because it has the capacity to conduct such trainings. The ZMLA programme was also given accreditation by NIPA as the institution responsible for in-house training of civil service personnel. In the past, NIPA used to train MOH personnel in management in a six months course

For sustainability, the "Provinces" must "own" the program. He likes several features of ZMLA including Provincial peer-monitoring as a training follow-up. PMOs monitor another PMO outside of their own province. He thinks that "when a PMO knows that one of his classmates is coming to monitor him, he may hurry to fix some of the deficits before his peer-reviewer arrives." He would call it an "indirect benefit" of the methodology. The problem with adhoc training programmes such as ZMLA is that they cannot train enough people in a sustainable way. Personnel in the civil service are rotated and others leave by other attritions. Then they are replaced by new ones not exposed to ZMLA. These new ones are the weak links which negate the ability of the trained ones. Curriculum such as ZMLA should like all trainings be institutionalized in basic training institutions of medical

personnel. This way, everyone in the health sector would have been trained and the new ones would not be a weak link.

One problem with governance of the health sector is that the community structures such as SMAGS and Health Centre Advisory Committees operate without legal backing. This fell away when the Central Board of Health was abolished. When its Act was repealed, the new law did not carry the communities structures. The Ministry of Health is currently working to give the communities structures a legal mandate again. This is advanced and the Ministry of Legal Affairs has already made drafts of the necessary amendments. (Interesting comment) "HCACs were from the old (Medical Board) system. They were abolished, but they are there."

Many of the trainees come from the provinces. Some of the TOT must come from the province. This separates the supervisor and mentor roles that can confuse the efforts to improve performance.

They have several MOH challenges to seeing the full impact of the ZMLA capacity building efforts including transfer of participants (often to other ministries!) Some offices strengthened at one level have no direct relationship with the corresponding office at another level (used "accounts" as an example). M&E is an issue, esp. in health and is often created in a vacuum. He couldn't provide specific PA reports with personally identifiable info, but offered to provide synthesized reports. (We would have gotten them at the time, but he couldn't transfer to Kumbutso's modem. We need to remember to try to pass by and collect them.

As a government agency, they often have legal barriers (laws) or government mandates that can be challenges to implementing new (implied innovative) approaches.

"ZMLA is a government program. It is important, but we need a program like the six month program many of us attended at PEDESA to be available here in Zambia. NIPA is probably the best place for it to be placed."

"Many projects come into Zambia with a program designed for another country and just want to implement it here (implying the ZMLA is different because it is their program)."

There is "too much repetition in donor programs." "I made ZPCT2 and ZISSP sit down together and coordinate because they wanted to do similar things."

Bottom line on ZISSP and ZMLA "What they have done is truly remarkable"

NMCC Meeting 041813
Chibesa S. Wamuzume, Case Management Officer, Acting for Director, Case Management Office.

NMCC currently under Public Health Directorate—will become Directorate of Disease Surveillance, Control and Research. Not sure if they are moving to MCDMCH or their correlation with the new ministry. IEC/BCC has gone to MCDMCH on paper. So will IRS, which is currently under TB!

She joined NMCC in November 2010. The NMCC provides national leadership in Case Management, Integrated Vector Management (IRS, LLIN), Epidemiologist (already transferred to MCDMCH), Entomologists, chief parasitologist.

Case management: until 2010 was filled by a partner until a huge gap occurred in 2010 with no donor. Now MOH has made ACTs a line item in the budget. Still not enough but better. S/P is also now in the MOH budget. Still isn't enough even with 24 million ($?) support. GRZ has actually made orders. DFID and PMI continue to cover ACTs, RDTs, Quinine, S/P. Peter Mara PS pushed to get anti-malarial drugs including 14 million for SP. You can find this in the "Yellow Book". "We will fund Directorate of Clinical Care and Support Services." Very high government commitment to procuring sufficient amounts of drugs.

NMCC Partners are: ZISSP, MACEPA, JSI/Deliver, AKROS, GF (Nets, ACTs, RDTs-UNDP PR); WHO technical advisor.

NMCC does policy and selects drugs for MIP, but MIP is at MOH RH which has moved to MCDMCH, so has FANC.

Technical Working Groups associated with NMCC: Case Management, Safe Motherhood, IRS, ITN, IEC (ZISSP support), M&E Malaria,

HW compliance is remains a problem. ZISSP helped with guidelines and refresher courses for Clinical Officers, Nurses, Lab techs, Pharmacists in Chongwe. Dr. Peter Mumba. ZISSP helped disseminate clinical guidelines for NMCC with help from their Clinical Care Specialists. The also printed treatment guidelines. Chongwe participants had never been to HRH courses, so they had the same HRH issues after training. She recommends they have more strengthening in counseling skills so they can learn to resist pressure to give antimalarials when there isn't any malaria. Prevalence in Lusaka Province is low, but ACT use is still high. If they use the Management Information System to look at:

- Number tested
- Number positive
- Number treated
- Drug given

That could be used to improve quality of case management and keep improper use of ACTs down. Logistics management is still a problem. (Is this part of ZMLA training?)
This year's Malaria Day will focus on cross-border initiatives with Zimbabwe, Angola and Mozambique in areas where they think they can eliminate malaria (prevalence is low).

IRS spraying involving ZISSP caused a lot of problems last year. ZISSP is not seen "as capable" in IRS. NMCC received a lot of complaints from the districts over payments to sprayers. Spraying stopped completely in some areas. IRS supervision was week in terms of local supervision. "Payment for IRS was a disaster." She recommends we followup with Chadwick Sikala the IRS supervisor (he was not there the day we visited) from NMCC for more details.

Interview Questions for Ministry of Health (MOH), Ministry of Community Development, Mother and Child Health (MCD/MCH), and National Malaria Control Center (NMCC)

Background information

Date:18 April_____**District:**_Lusaka MOH

Title of Respondent _Mrs. Mshanga, Director of HRA; Catherine XX Associate Director XX?
Sex: Female_XX _

Enumerators name_Beatrice, Paul, Deborah

SECTION 1. PROGRESS TOWARD RESULTS–Improving access to and utilization of FP, HIV/AIDS, malaria, MNCH and nutrition information and services in ZISPP target districts

Director provided general overview of what the HRA Directorate does.

Team asked: Which of these activities does ZISSP specifically support? HRIS, retention scheme. Director is not happy with how support happens to retention scheme; with Directorate having to pay up front and be reimbursed later, since they don't always have the money to front and have to dip into funds allocated for other activities, then wait to be reimbursed by ZISSP. Also not happy with limited number of 119 workers, had hoped more would be supported over time. Gov is running the rural hardship and remote scheme. Asked Is zissp topping this up or matching this support for specified workers? Got seemingly different answers about this. Clarify whether zissp scheme is same or different. Response to question about sustainability of workers retention scheme was that government was already doing this, but not clear that the two schemes are the same.

ZISSP has supported them by sending people to the Harvard School HR Management training, 2 people at a time, had identified 2 more people to go, but have been told by ZISSP that cannot continue sending; zissp has said money must be reduced. (Ask ZISSP if and why they are cutting back promised funds) Director gave a few examples of scale down of ZISSP supported activities; they were asked to choose between sending people for trainings or continuing to receive support for quarterly meetings. They chose quarterly meetings, where they discuss and do CB.

Payroll Management System, was not ZISSP's program (is this accurate?). There were administrative rigidities to release payroll system to individual ministry so didn't happen. From her description, sounds like they've hit a brick wall, but Elizabeth suggested there was hope for this. Had hoped to tailor system to each ministry, but reluctance to allow MOH to do this. Not sure what will happen now.

In terms of internal systems within the MOH, ZISSP has done a good job. Were supposed to use computers to start computerizing payroll? Records, but were told by ZISSP that their requests went late, so had to look elsewhere, for computerizing the HRIS records. They had to use government funds to buy the computers. Ask ZISSP what happened with this.

Funds did not come through, told they had requested late, had already ended the year. So GRZ had to procure those computers. We should have asked how many they had intended to buy and how many they actually bought

She praised Elizabeth's CB and mentoring support for less experienced staff in the office. Secondment caliber of staff – too much disparity of two seconded staff – one was too

qualified, the other not enough, not the best complementarity, would have preferred more middle level staff. maybe ZISSP should better balance their skills, Elizabeth very skilled, ChiChi more clerical level. Impact not felt so much, everything up to Elizabeth.

Workload Indicators for Staffing Needs tool, ZISSP provided support to roll that out.

Performance Management Package – she said ZISSP had scored 100% on this one. It was a tremendous job done by ZISSP. Both TS and FS for roll out. Also tools were developed centrally.

In terms of job performance, key things achieved: she said has seen tangible improvements in capacity building especially in record keeping and also general HR management.

In terms of partnerships, also said ZISSP does not dictate to them, rather they plan and work together.

Asked about pool of trainers, whether it is working well, she thought yes but not sure what was happening in other directorates. No complaints in terms of trainers going out to train others.

Question on WISN: an initiative introduced by WHO; but no funding, ZISSP came in and were able to train staff and is now ready to roll out, tool not yet being used. (Follow up with ZISSP and ask what is their planned support for roll out?)

Ask ZISSP why they are reducing initially anticipated funding for HR activities?

Eliz has done a lot with coaching and orienting new staff, developing an orientations package for new staff.

She had an issue with CB managers role; not very involved with them apart from reviewing training curricula for CHAS and helpful with that.

NIPA supposed to be training institution for HRA (but didn't' seem to be happening).

In terms of ZISSP's support was for curriculum review for CHA program, but CHAI provided more support for funding. She didn't know anything about training for supervisors. Or contribution to data collection tools, that might have happened through a different Directorate. Why didn't she know about that?

Asked what indicators would measure for her Directorate whether capacity had indeed been built: she answered having less HR complaints from the field; number of staff confirmed at correct time. # of people retired at right time (answers have to do with records management, with the HRIS).

Asked if anyone from HRIS team could usefully talk to; that's when she suggested Mr. Lazarus Malenda. Also mentioned Phyllis Shisha. Reschedule with lazarus malenda and ask for a blended interview?

For coordination, Paul asked whether they were liaising with HMIS unit in setting up the HRIS system, she said yes, they sit in the same team. But which Directorate should be responsible for hosting that information system?

We may to clarify with ZISSP whether does HR have a statistician? Is it realistic to expect HR can manage an HRIS independently?

SECTION 3. HUMAN RESOURCES FOR HEALTH

25.	In what ways has ZISSP strengthened MOH/MCDMCH/NMCC capacity to attract and retain health workers in rural positions and areas?
26.	Do you think this will be sustained the after projects ends?
27.	How is ZISSP with GRZ measuring differences in quality of job performance and/or health services as a result of trainings it provides at provincial, district and HF levels?
28.	How does ZISSP with MoH/MCDMCH/NMCC measure whether having a broader pool of trainers and tutors in target provinces and districts leads to improved health services quality and utilization?

Will schedule a follow up interview for workers retention scheme.

Thank you for your time and the information you have shared. Reiteration of how information will be used. Provide contact details in case interviewee has any questions after interview.

Provincial, District, Facility and Community Interviews

09 MAY – Team traveled to Lwangwa, picked up interpreter, arrived at DMO office around 2 30 pm. Met with DHM team members present, then split to interview various team members. This is the first interview with DMO, also left Likert mini survey with him.

Dr. Moderm Bwalya, DMO, also Petronella, HR officer; Victoria MCH Coordinator; Accountants x 3; planner.

Team also includes information officer, public health officer, clinical care officer,.

General question: ZISSP has told us this district is one where their involvement has been strongest. Can you tell us what are the main things ZISSP been doing in the district?

Has revamped the SMAGs and provided support materials for them: bicycles, torches, bags, registers, rain gear. Has been doing a lot of training, although not yet for EmONC. ZMLA has trained nearly the entire DHM team over a period of a year. This has involved quarterly trainings, mentorship and a group approach to a case study in Kasinga. Also the Lusaka province seconded ZISSP clinical care specialist Dr. M. has been coming for malaria trainings. Mrs. Nakawala has come for data audit. Bridget, the CHC, has been working with SMAGs and BCC committees.

Question regarding whether district team is working with the National Health Accounts? Yes, they are easy for us. "They are maintaining books."

Question for HR Officer: Have you used any databases that ZISSP has developed for HR purposes? Any new systems? No, not yet.

Group split, Deborah and Kephas remained with DMO.

Can you tell us more about the ZMLA trainings for your district team?

They were done between November 2012 and this year in March (not a year period). Have trained the entire team except two people. Also they have provided trainings for HC staff in malaria case management, most of our health centers in district are run by only one professional staff, so have been training these people at each HC.

More about the ZMLA training – how has this training changed management procedures within the district team, if at all? It has helped us in planning, in making action plans, revision of the plans, using evidence to make decisions, problem solving as a team.

Also ZISSP has helped us to conduct meetings more efficiently, manage time better. We are also doing better reporting as a staff on when we arrive, when we are out, where are going.

At Kasinsa, we have worked on M&E. For the case study, we set objectives and time frames for meeting them. We worked in 4 groups; one focused on ANC, one on PNC, one on Emonc and maybe one on institutional deliveries. We identified these as problem areas then set goals. One goal was to increase PNC from 45% to 80%. So put many things in place, set up the HC as an EmONC site, trained staff in EmONC. DOH has provided some supplies.

ZISSP has helped us focus on delivery of quality services. Staff training is one strategy. Also clinical care mentoring, and technical support. For QI, we have looked at infection control for all HCs.

Technical support is very hard; the DHO has only one vehicle and it is grounded. The PHO gave us one, but it needs tires. We have to use that same vehicle for transporting obstetric referrals and for all technical support and other visits. The only district hospital, Katongo, is 50 km away.

Each of us on team has written a work plan, includes how we will share vehicle use, so for visits we plan to drop one of us at a time at HC along the way so we can work there and then be picked up on way back. This way can do many visits same day. The DHMT is not meant to sit in our offices, we are meant to provide technical support, M&E, performance assessment. How to do this with just one vehicle?

The malaria case management involves the use of RDTs and treatment. Only two HC have microscopy capacity, the same two that provide CD4 testing and ART, the hospital and ??. We do have mobile clinics that provide some outreach and carry ART out to communities.

Has ZISSP played any role in clinical mentoring for ART? Yes, through the province they have been assisting centers to be accredited for ART. Doing this with Dr. Matabini.

Does the district have a clinical mentoring team/ Yes, we have 2 mentoring teams: one for MCH and one for other clinical services. The MCH team is focused on reducing maternal mortality and includes midwives, we have assigned midwives to mentor specific health centers. (is this part of the new 'parenting' strategy described in 2013 quarterly report?)

The other team includes lab, pharmacy, clinical care, other medical staff.

Ideally the MCH team would go out weekly but can't due to transport problem. So hoping to go out bimonthly or monthly.

Has ZISSP been involved in annual planning process at community level? Yes, Bridget has trained the NHCs.

How do you handle the community budget allocation when your grants are reduced? They get at least 10% of whatever goes to the HC. We indicate what part of the budget is allocated for community and that remains with them. This is true for all HCs not only those supported by ZISSP.

General question about sustainability of ZISSP interventions: Lwangwa is one of the strong districts, before ZISSP there was HCP and HSSP, much groundwork has been laid by those projects. There has been gradual building on a strong foundation. These activities are not new.

Will the capacity built by the ZMLA training be sustained? Yes, we have the soft copies and hard copies the training materials; if we forget, we can refer to them.

Has the district benefited from the various guidelines ZISSP has supported the MOH to roll out?

The ZMLA training really helped with this; ZMLA was very good in linking us with central level. We got many guidelines from the training. Accountants know how to use impresses for procurements. Also HR guidelines; 'they are there and we are using them.'

As a district our emphasis is that everything we do feeds into the MDGs, whether the services are to reduce malaria, HIV/AIDS, maternal mortality. We emphasize that everyone, what they do, contributes to this, even if they are cleaning the toilets, they are keeping the health team from getting sick so they can continue to do their work. Everyone is contributing.

Are you aware of any Baby Friendly Initiative assessments done by ZISSP in the district? No, maybe at hospital, but they have done IYCF training here.

In this district there are only two HCs that are equipped to do deliveries the hospital and ?? We refer others to Katongwe. ? Clarify the 2 facilities are.

The Society for Family Planning has done training for the district team and HWs for misoprostol guidelines, they also emphasize bringing mothers back to HF after home deliveries for PNC. A team went from district to Kabwe to become trainers – MCH Coordinator and Clinical Care officer.

He listed which staff were trained at which HCs – total of 15.

Are there CHAs in this district? Not yet, his understanding is there are none in Lusaka Province.

How long have the SMAG groups at the 4 ZISSP support HCs been active? Since last October. They are very active.

Have you seen behavior changes as a result of their work? Husbands used to accompany wives to ANC only at Kasinse, now seeing this in other places.

Have you seen any ZISSP focus on gender? Yes, in terms of gender balance for training participants.

But this can be difficult because more men are posted as health workers in rural settings.

Of the activities and support, what in your view has made the biggest impression for the district?

Biggest impression (he emphasized 3 times) is that they trained us in ZMLA. In this group, there is me and then under me there are supposed to be HR and other officers who have degrees, but here no one has degrees. After the ZMLA training, they understood what was required of them. Capacity has been built for them to be managers.

There are other partners, but they are not focusing on this. CDC focuses on TB, HIV clinical management, not CB for managers. CIDRZ focuses on case management for clinical staff.

It would be good for every district and every province to undergo this training. We had some provincial people in our group at first; I think some of the district team may have been intimidated by their presence.

Mutual review of training register for 2013: only CIDRZ has done IMCI training this year, Z has done in the past. He was trained by ZISSP in IMCI as a trainer.

Have there been other TOT efforts by ZISSP? Yes, in EmONC, still doing a training now. Says much better to do the training in a way that includes the start-up logistics/supplies and then give DOH time to be able to keep the logistics going. For FP and EmONC.

Is PPAZ here? No, not in this district. A partnership that may not be fully explored for FP is with Child Fund.

ZISSP has done a BCC training here, the MCH Coordinator can describe.

The biggest barrier for the district is transport. If ZISSP could help there would be most useful.

Maintenance is always the issue. Is there some way that partners and DOH could share transport costs/maintenance to make it easier for partners to buy in for this?

ZIDRZ is helpful; their BOMA project has a vehicle and they share it.

This is larger issue to bring to USAID if team has any suggestions.

Chipata Interview with Provincial Lab staff

- Trained in QI and a member of the provincial QI team.
- Support district level QI. Lab QI was there even before ZISSP except the ZISSP training has led to improved internal controls. Have a tool or template that they use for QI and look at the different tests conducted by laboratories including storage of reagents.
- QI is normally facility oriented, prompted by gaps identified

Changes seen with ZISSP Support

- Training was conducted in December last year
- Now have standardized tools for assessment
- Supervision of district staff is now being conducted and hands on mentoring is provided.
- Although there is no RDT QI/QA system, we ask the volunteers to keep used RDT cassettes and bring some these as they come to collect new ones. Although not reliable, we are at least able to counter check some of the readings.
- I work very closely with the clinical care specialist – ZISSP seconded staff.

Challenges

- Very few lab staff. Most labs are manned by microscopic
- Limited equipment and in most cases old. Takes longer to repair once the equipment breaks down
- Frequent reagent stock-outs
- Most health providers prefer using the Rapid Syphilis Test which is very expensive

Recommendations

- Scale up QI, for example out of the 20 CD4 centers, only 9 participate in QI. The rest just rely on indirect assessments - sharing with other centers for cross checks.
- ZISSP should support transport for supervisory visits to districts
- ZMLA training should be extended to lab managers. Also need to be trained in PA – Although we participate in PA, we have not been trained.
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Chipata: 13 May - Interview with Rebecca Lusumpa, ZISSP SMGL Provincial Coordinator (mentoring 2 districts Rundazi and Nyimba) and Mukata Mulunda, ZISSP Community Health Coordinator for 3 districts

Also briefly with Joseph Mseteka, Principle Nursing Officer, Maternal Neonatal and Child Health – having national launch for Safe Motherhood soon, having preparatory meeting, available for 5 minutes

What are you doing in area of maternal, neonatal and child health – how and what ZISSP supports.

What we do as province is coordinate activities of RH in this case narrowing it down to maternal health, neonatal health and child health. Under these we have a lot: maternal health – antenatal services, counseling services within ANC for PMTCT, FP, delivery services, Postnatal services, child health. Under antenatal, divided into first 20 weeks and other 20 weeks, gestation is 40 weeks. So problems we find there is that women tend to book late, so other activities are slowed….low IPT uptake because of late booking, would be also nice to find that where we have partners coming to assist, they are strengthening community engagement so that clients are able to book early; the earlier they book easier it is to manage pregnancy. Find that where SMAGS are active or other community involvement is active, maternal health indicators show improvement. Within this we have delivery services; have some challenges, some pockets of society that are inclined toward home deliveries, so sensitizations go on by mass media, drama, and SMAGS are on the round. Next week is safe motherhood week, want to prevent maternal deaths thereby improve on safe motherhoods. Not only about a woman being healthy but all other areas from ANC… in areas of delivery, apart from women not wanting to deliver at HF, there are also issues of inadequate health personnel. We have few midwives in the province, trained midwives to undertake skilled delivery. apart from that, women would love to have a facility delivery, but then they will stay far away from their villages or homes and at that institution there is no room suitable to offer accommodation for those clients. These are some of the challenges. W omen would travel to maternal waiting homes. Because maternal health is wide, we also have some challenges in following up women who are HIV positive; if they after delivery they come to clinic for late booking, deliveries happen in village, they don't bring child early for PMTCT services, so these services can't start at booking time. Follow up becomes difficult, difficult to start with ARVs. We are looking forward to Option B Plus to start, will be an advantage for us. It has been introduced, waiting for guidelines, haven't begun to implement.

We would have started but needed clear guidance. Need to orient health personnel in districts. What used to happen is here is a client who is HIV positive, and then she has low hemoglobin, so cannot go xxx woman who used to be practitioners would give them full HART instead of PMTCT services. We also have issues of child health: we are not doing very well though we are there, but want to see us more than 90% for targets. Challenges: in health centers: problems with motorbikes, long time since MOH gave motorbikes to HF, transport for outreach is a problem, motorbikes need maintenance. Maybe district has 3 motorbikes and 40 health centers. Also problems with vaccine fridges, they are there in HF

but are old, cost of maintaining them is quite high. There are some districts like Nyimba, some parts of Rundazi and Mambwe are in valleys with very high temperatures, so fridges for vaccines not doing well (kerosene); we are lobbying for solar fridges. The current vaccine fridges are convertible from kerosene to solar; we need new vaccine refrigerators, WHO has ruled out the current ones. They are outdated.

Cost of maintenance is high. Other issue is FP; we have a range of fP services to provide of many methods we have, one of the methods is a problem to offer to community is LTFP because there are few trained providers to give. Don't know about Jadelle, IUD, very few personnel who are trained to offer the service. In each and every district in EP, the demand is very high. HW may have the commodities, methods but not trained, so am confident to give the short methods. The female condom there is very little demand. No demand from the women, but demand is there from the male, but few men will actually use it. Would rather go for male condoms. Community is looking for LTFP methods, especially Jadelle.

What difference is ZISSP making in these areas? The contribution is great and commendable because their systems strengthening is not only strengthening the few districts where they are but also the province as a whole. These two officers have just been pulled from Mambwe district, were conducting smag trainings.

CHC Coordinator: Describes trainings for NHCs to make community action plans.

We trained the HC advisory committee representatives, started in Nyimba.

NHC members are doing growth monitoring, data recording, many things. There are areas where they are not active; during the last PA will tell you "I am alone at this HF", for me to engage the community is a bit of a problem. Others will say the officers are no longer working in the NHC. Other challenge we are working on is documentation of activities; sometimes you won't find documentation of community engagement even if they are active. They can't get money from budget unless the documentation is there, can only happen if NHC is active. Maybe some documents are missing. You ask them, they will say yes are meeting.

Look at planning, what are key changes that you've seen happening at community level as a result of trainings for NHC members. Changes we are seeing, though it was happening before it was just on periphery, usually community activities were not much more than cleaning, or maybe for buying fuel to do outreach activities. Even the process for involving communities in planning, it was not there.

We are working together with saving mothers giving lie. Our role is capacity building; there we are looking at trainings for SMAG members. In the training we are doing right now the SMAG program is also undergoing modification; last time people went for training in 2012, the information was same but reporting was different. The registers, then we only had one book, but now the team that went to Livingstone using 2 books, they are refining the model, including the reporting system.

Now they have baby registers. We are ion the loop, those changes are just minor. We have our pool of SMGL trainers. 18 trainers, all of them MOH trainers as owners of the model. Let them do the training, do the supervision, so they own it for sustainability. World vision

is training SMAGS in Rundazi, another one, child fund in Nyimba, very soon we are going to work with rising fountains in Rundazi. They are all grantees from ZISSP. They are yet to be awarded. Tandizani (in Rundazi) and Child Fund have received their grants and have started training in Nyimba (child fund).

We gave them 7 centers for them to train; using the same Ministry facilitators.

Are the subgrantees utilizing the same 18 trainers form the province? Yes. This is a policy for the province, want similar training approach for all. ZISSP is directly the smags they have trained; zissp has provided wrappers, bikes. World vision also supports some. Child fund also supports some.

Giving one bicycle per zone. It's a challenge. They are all working, they are walking, they are complaining, they all don't have bicycles, how do you decide who gets a bicycle and who doesn't'? best answered by HF. Maybe it stays at HF, those who are near can use it. Or bicycle can be at furthest place from HF, so can pick a woman and carry her. In Rundazi there are bicycle ambulances with trailers at the time where a woman can lie down. There is a cushion. The SMAG will ride the bicycle and pull the woman. That was supported by Africare in the past that was 2 years ago before ZISSP. They are still there. these ambulances have a shade canopy.

The new grantee has that in their budget to buy the bicycles in their budget - Tandizani in Rundazi under ZISSP is going to fund this.

Since smag started what are key changes you've seen? There are a lot. in communities majority of women in villages don't like delivering at health facilities. They used to deliver at home. It was difficult; you would find that where there are complications they would end up with fistulas a lot of cases of fistulas in runduzi, 170 women repaired here at hospital, doing maybe 50 or 60 in two weeks, they were both young and old. A lot of young marrieds, who did the repairs? That was under Africare. Then unfpa. So unfpa is doing the same from Monday next week to do surgeries. How many are booked for next week? Will have over 50 maybe over 100 this is a provincial call for fistula repair. This will happen during safe motherhood week this is unfpa contribution.

When safe motherhood came on board with sensitization women came to know that it is important to access health center services and deliver from health facility. Smags have been sensitizing. In past there were not sensitization. But with coming on of SMAG program.

Even the traditional leaders are part of this; they would even say in past it was a taboo to talk about this, because some health centers have male nurses and midwives but now with sensitization they are accepting. In Rundazi and Nyimba for every woman who delivers at home they charge the family to pay a goat.

The SMAG program is also focused on male involvement, men are also trained, and they work with menfolk. You would even see a lot of men accompanying their wives for antenatal.

In past they would not even be mentioned. The SMAG model was there as far as 8 years ago; the MOH trained the HC staff in Kabwe on SMAGS. When they went back they formed the SMAGS. Because of lack of support, for gov to do what ZISSP is doing they couldn't manage. You go there you ask do you have SMAGS. They would not be active. There is no one to follow them up, there is no one to motivate them. Even the HC staff did

not even that the thought of following up the SMAGS. This time with coming on this program, the HC staff now coordinate with the SMAGS.

Would fine the smags and HC staff having meetings every month where they bring their monthly report books and give data to HC staff.

How do we make sure that smags will continue after zissp stops? That's why we are working with the HC staff; we are strengthening the system, in the past the HC staff didn't' know they were supposed to work with communities, call for meetings, motivate them, but this time they are doing it, we are not there every month, when they met during the month, the HC staff find a way of providing support to the smags. This is what we want as zissp; we want them to own the program. they are doing that. By the time zissp goes, the trainers who are MOH staff will still train more smags using gov funds. When we are gong the same HC staff will continue meeting with smags and community leaders they even remind the HC staff that we need to have this meeting. During their planning meetings, the budgeting, they are involved in the HC budgeting to make sure that communities are not left out. that way when zissp is gone we are so sure the systems will be strengthened and they will be able to stand on their own.

What are the signs?

Community meetings are happening without our presence. Community leaders are involved in monthly and quarterly planning meetings. Even at district level, eg in nyimba, the DCommissioner chairs the District partners meeting and the traditional leaders are part of that meeting, they also meet, these are the people who go back to communities and share information. For example, was in Nyimba last week of April, found there as a meeting with DC and stakeholders, where in some areas where some women still deliver at home, come up with an extra charge apart from charging woman who delivers at home, they would charge the headman in that area would also be charged for not sensitizing community.

Not an ideal situation, maybe depends on chief who knows their subjects. On a lighter note after some time, when people are used, they know if you do the wrong things they will be charged, a punishment can also be aw way to help change behavior. When someone that this behavior is wrong, it is chargeable, those who come behind will automatically follow suit. With the smag sensitization and awareness, behavior can change after some time.

What role is zissp playing in establishment and management of maternal waiting homes? Just supporting the MOH through the Performance Assessment to identify gaps and then the maternal waiting gpas are one of the needs that aware identified. Eg for Majewantu. Women don't want to deliver the, the waiting home is dilapidated and the delivery room is near the screening room. Now that we are part and parcel of the provincial health office staff, we work along to support these recommendations. But zissp is not supporting the construction materials. Zissp is involved in the coordination of partners who are involved in construction.

In Mundazi, cidrz said they would construct 17 waiting shelters, zissp's role is to check and see whether they are doing this. Even in nyimba, those that have they will construct, part of the SMGL coordinator job. Also the district coordinators do the same.

Zissp has provided equipment before; EmONC was provided in Rundazi and nyimba, ZISSP left it at district health office. Doing this for the SMGL districts.

ZISSP is coordinating some of these activities, so we have cidrz that promised to buy the equipment, then we have the RBF that has bought equipment for Rundazi and Nyimba as a control.

For CDC, they will say it's based on whether we have funding or not. all those good plans and maybe equipment comes and maybe not.

SMGL saw in HF when we did some checking last year from June to December we could see increases between 2011 and 2012.

We have formed BCC committees in 3 districts; they are active; what do they do? Their secretary is the DMO; committee is comprised of partners and DHO. Have not yet formed at community level. Behaviors are identified for change, materials from central level are chosen and used in specific places. We are about to train we had a CB on Behavior centered programming, was talking to provincial aids coordinator, want to train HF staff in this. Have already provincial staff in TOT, supported by NAC, ZISSP went there as trainers. This ids an HIV/AIDS specific activity supported but you find that's broader, because it's a behavior centered approach. Intention is for it to be integrated…..can include FP, malaria. Other.

This is where you can see partner collaborating. Ask to talk with committee members in Nyimba, including DMO.

We met chairman of chiefs, introduced zissp, what we are gg to do in provinces, happy to involved chiefs, don't worry about money or permission. Have agreed to be part of health program work. Here in EP there is understanding that chiefs are change agents, partners.

No zissp budget for gifts for chief.

Chipata.PMO.Key informant Interview with Provincial and District Staff - Comprehensive

INSTRUCTIONS

Thank you for taking time to participate in the ZISSP program evaluation interview. My name is_____ and I will be asking you some questions which will guide the interview process. The information provided will be handled with confidentiality.

The questionnaire comprises three sections; background, capacity building and human resources for health. Both open and closed ended questions are included in the questionnaire. The closed ended questions have instructions for ticking the appropriate option, and providing descriptive information when requested to list and specify. You are required to provide descriptive information for all open ended questions

Section One: Background information

What is his name? **Date:**_13 May_ **District:**_ Chipata, Eastern Province PHO **Title of Respondent** _PMO__ **Sex:** Male X Female **Program Area (if applicable):** **Enumerators name:** Beatrice, Deborah, Kumbutso

Section one: Progress towards results	
1.	In your view, has there been any progress in ZISPP supported districts in the following areas: EP has been beneficiary of ZISSP support since its inception. The placement of seconded officers at PHO has been done in line with identified gaps at HPO level. We have 3 officers based at this office, CCS, MS, CHC. Basis was some identified gaps first in structure for MOH, coming to the CCS, at that time gov did not have CCS who were medical doctors who were able to provide overall oversight in issues of clinical care. You find that at that time in many provinces these positions were held by nurses , it was a challenge when it came to supervision for doctors; we saw the limitations of nurses in terms of overall clinical issues, so ZISSP responded to the gaps by supporting these CCS. Over the years, results have been seen from that area, in since that clinical care aspect has received more attention than in the past.
a)	***Training:*** General case management trainings are supplemented by ZISSP in terms of financial resources and expertise. In training of clinical care teams, we are trying to ensure that clinical care teams are the backbone of the whole clinical care aspect in province, so ZISSP has been supporting us, in the actual formation of teams, training and mentoring. We hope to continue to receive support through ZISSP. As you may be aware, the Ministry hasn't done very well in terms of QI, years back we were talking about QA committees but with attrition and other factors we lost it, so in the last year or so with ZISSP support the MOH is getting a lot of complementary support so that we can activate these QI teams to help us at all levels for clinical car issues. So in mentoring issues of QI, adherence to treatment protocols and clinical cross cutting issues, ZISSP is supporting us. Some may not be workshops or classroom trainings, the concept of mentorship is well appreciated, that one tends to be hands on where mentors and mentees interact in the field and the job and this tends to produce better results than didactic type of learning. We need to do more in that area to ensure that all teams at all levels are very active. We have a management specialist at PHO placed by ZISSP, there the focus is to strengthen systems, especially in areas of planning and management, basically at all levels, starting with provincial and hospital and then district, primarily in EP ZISSP support for some of these priority areas is in the 3 districts, Mambwe, Nyimba and Lundazi. The

	idea was to fully support those, make a difference, and decisions would come later about scaling up to other districts. Under MS, the question is how do we focus on strengthening and improving leadership and management capacities in general of all those managing health services at various levels, including planning. Planning has been done in the sector for a long time, but people entrusted with these processes have a high attrition rate, some are coming on recently so cannot assume their understanding is the same. That support from ZISSP has completed gov efforts. When it comes to initiation of planning process, for a year we have been getting support from ZISSP. Apart from the expertise of the management specialist, also financial resources so can call districts together, prepare them for planning, including documenting whole process and final product, which are the 3 years medium expenditure frameworks, plans and budgets. ZISSP has really supported us, including revision and production of planning handbooks, to have a uniformed and harmonized process including the resource materials. Guidelines are used so process is same for all provinces and all districts. The way we have been working is that all of these processes are integrated (planning, M&E); our ZISSP seconded colleagues are fully part of the structure here, we do things together. Part of the monitoring activity we do is Performance Assessment, which this office does biannually with all districts, hospitals, and training institutions. ZISSP colleagues reinforce these assessments. We also do technical support, in the health sector, you plan, implement, problems are identified, at same time you need to go and see what challenges are in the field; ZISSP has been supporting us to ensure that we provide TS through expertise of colleagues and also provides financial resources at times. (I think he is referring to clinical mentoring here). One important thing has been Z supplementing gov on emphasizing important of documenting the planning process, best practices and also whatever we do in terms of reporting, for instance last year we were supported to produce the annual statistical bulletin, gives good overview on how province his performing, good example of supplementing gov efforts. This has been institutionalized. For this year this office has gone ahead to produce its own statistical bulletin without external support. Has happened from that synergy with ZISSP. Other area where we've received support is with presence of the ZISSP community health coordinator here, where focus has been how do we enhance community engagement and participation? As a sector, we have seen that one area we are weak in is link from community level to the HF, how do we strengthen community participation in all that we do, from planning phase to actual management of programs and services. Again focusing in the 3 districts, ZISSP has trained community members in how to participate in health planning and management of health program. There is still a lot of work to be done; one of the challenges is how do we keep the community motivated to participate in health programs. Education does same approach, agriculture does same, everyone is targeting the community for volunteer work. Sometimes it becomes a challenge to have a motivated community representative that is always eager to participate. The strategy is to orient and train them, with ZISSP support that has been happening with NHCs. It is the smallest structure made up of community representation out there in the villages that is supposed to provide a link with health

	facility. The other community structure is the health center committee; ZISSP is supporting gov to train members. Whole idea is that health service delivery should be people driven. The people who know the needs of a catchment area are the community members. Outside of that have some community structures being supported by ZISSP to form and strengthen, eg the Safe Mothers Action Groups, quite a number have been trained especially in the 2 districts of Nyimba and also Mambwe and this is ongoing some targets have been set to achieve. One of areas of priority by ZISSP is MNCH and nutrition; we hope with strengthening of these community structure already there is improvement in performance indicators at provincial level in MNCH. One example is that institutional deliveries in province have improved, maybe from 30% 10 years ago, now about 70% in deliveries at hospitals. Of course this is a result from a number of partners, but ZISSP has made a significant contribution. There are many other performance indicator s that have shown improvement. Also in that same area, there is this concept that has come with support from ZISSP, the issue of providing grants to cbos so that we create demand for health services. We hope that if we sustain it and do more, it's going to answer a lot of problems, one of challenges of community engagement is how you keep them motivated, issues of empowerment, if they are provided with some resources through these grants, that in itself is going to empower them, they are going to have tools and resources to create demand. When it comes to demand generation, the community is key. That's another important aspect of providing grants to selected community members. It is well timed, although relatively new. In the coming year or so more can be done. Another area in training and beyond training is in malaria. In the introduction we talked about IRS. EP has highest malaria incidence in the country. Currently it stands at about 599 per 1000. That figure is very high indeed. Consolation is that we are seeing a downward trend. Last year we were in range of 756, year before 821. Worth noting. One of major reasons seeing this downward trend in malaria incidence is support from partners and ZISSP stands out. For instance this past year had almost 100% support from ZISSP in IRS, training operators, managers, stores officers, clinicians to manage poisoning from insecticide use, all conducted prior to initiation of spraying and some afterward. The IRS was by and large supported by ZISSP and we scored success just this past year; our target was to spray 85% of targeted structures. We attained 83%; there were 2 districts that didn't do well. The key message is to thank ZISSP for that support. Coupled with observed trend in reduction of malaria, we are saying interventions are working. It is not only IRS; there are other interventions to reduce malaria. This is first year that all districts in EP were involved in IRSA and supported by ZISSP and we hope this year with further support we can reduce much more. Does Z pay for allowances for sprayer? Yes, it's the whole package. But explained that sometimes use environmental staff in their own communities and in these cases don't

	pay DSA since they are working near home.
b)	***Developing training manuals/resources:*** Didn't ask
c)	***Developing policies, strategies and guidelines***: Mentorship guidelines had a launch done and guidelines disseminated. For quite some time with mentorship there were different partners, no harmonization, so that was put together. Was training done in use of guidelines? Training in fact has been ongoing but people can refer to guidelines now. The other one is QI guidelines, again all trainings we are doing are based on that. Recently we held some trainings for provincial team because issue of quality has to permeate through all levels, across districts, that's why the multidisciplinary teams, those guidelines have been launched and distributed, the ones how being used. ZISSP has also been involved in production of planning handbooks to guide process and these have been periodically reviewed. And periodic updates for revisions are done. A number of other guidelines where ZISSP has provided TS to MOH: recently the Adolesent RH guidelines, ZISSP had strong input to that. Have received them here. For misoprostol, did the launch at same time for these guidelines. The PS was there, ZISSP COP was there, launch and then copies were distributed to guide operationalization of those areas. For misoprostol, EP was part of the pilot, Pataoke district was a pilot site, some years ago, agreed that would reduce PPH, next stage was to formalize everything and come up with guidelines now disseminated, the challenge now is to ensure adherence and support districts so they utilize it. We say let all mothers deliver in HF, but we give misoprostol so that when w omen deliver wherever can take the tablet to prevent PPH. Some districts are able to access through medical stores. I think our HF are aware, where possible there they assess a woman, where woman appears to be a risk, if you visited some HCs you may find that they have it. We are encouraging institutional deliveries, but not all women can do that for various reasons.
d)	***Conducting Research and assessments:*** Not asked
e)	***Systems development and sound strategic approaches:*** Not asked
f)	**Community mobilization for maternal and neonatal outcomes.**
g)	Other (specify):
2	In your view, have ZISSP activities affected any changes in the following areas: *Coordination of key stakeholders; ongoing clinical mentoring, Supportive supervision, Providing human resources through seconded expert staff and support of retention scheme, Providing*

	financial resources, Participation and provision of TA support in national, provincial and district MOH planning and budgeting activities, Implementation of grants program/capacity building of grantees in grants management and organizational development
Section two: Capacity Building	
3	What ZISSP strategies or activities are you aware of that have helped to strengthen community participation in improving health? **[Prompt for SMAGs, NHCs, HCAC]** Are SMAG services of quality? You know even trained TBAs are supposed to be smag members, the messages is that people from community should not deliver, deliveries should be conducted by skilled attendants, so role of smag members is advocacy, creating demand, encouraging referrals, auxiliary responsibilities. Yes they are doing a commendable job. The challenge is how do we maintain their engagement, keep them motivate? That is where any interventions that come in for motivation will go a long way to supplement their work. I think they are a good group to have to supplement efforts of health sector. May be very difficult to say whether they are doing quality work, we are using them more to generate demand and that is a plus to us. We are emphasizing that they are not left alone; they also work and lean on other structures like traditional leadership. If the district is also reaching out to them through supervision and providing opportunities for them to participate you find that they have that a sense of ownership. Postnatal attendance within 6 weeks, even if longer than we would prefer, we have seen an increase in that and a few other safe motherhood related indicators.
4.	Based on your experiences or observations, how have ZISSP community focused activities addressed gender issues (e.g. household decision making, gender imbalances among health workers or volunteers), if at all? Any gender analysis done during the planning process? Before we talk of ZISSP, as gov gender is at policy level an approved way of thinking we even have ministry of gender, we have been directed as sectors to mainstream gender, some weaknesses exist but we discuss and see how we can strengthen. Even some of those monitoring processes it talked about, they assess to what extent gender is being mainstreamed. From planning to program implementation we are aware that gender is to be mainstreamed. To be frank, we need to do more than we've done. Yes, that is always talked about and considered. It's an issue of implementation which is a challenge. (Deb: I read this as essentially "No, ZISSP hasn't addressed gender issues")
5	Based on your experience or observations, do you believe that quality of care at community level has improved? If so, what groups of community members have benefited most from ZISSP activities? Are there still groups that are yet to be reached?
Section three: *Human Resources for Health:*	
6.	In what ways has ZISSP helped to attract and retain health workers in rural positions?

	We do have people in the province on the scheme. Yes it's working, very much. Maybe the implementation has its own challenges. But a lot of good results. About 125 people on the province are on the scheme. It tends to retain staff in the hard to work areas. Have seen this happen; HFs that never had trained health worker, they now have, people have opted to go and serve because the scheme provides that support to them. What are challenges? With recruitment, maybe DMO will recommend staff to be added, documents come here, we support, goes to Lusaka for rechecking and approval, then that person is captured and goes on the scheme. Through this process a delay could occur. As a HW once I fill in my forms I expect to be on the scheme. *Do you know if any workers in this province are supported by ZISSP to be on the scheme?* Normally the support is in a basket, difficult to know where it's coming from. Know that ZISSP has been supporting even the technical aspect of how to manage the scheme, they have seconded staff at national level, to manage the scheme, manage the data, clean the data. Sometimes entitled workers may not receive timely payments. Depends on funds available at national level. Payments don't come together with salary. These are major challenges. Retention scheme needs to be continued, supported and expanded. We have cadres of trained personnel that weren't in remote posts before.
7	In your opinion this context do you have an opinion about any benefits of the following specific capacity-building programs promoted by ZISSP:
8	What are the most important issues related to attracting and retaining health workers in rural positions that need to be addressed in the next two years?

Section Four: Coordination and Integration

How are you as PHO coordinating the partners within the province to make sure that components come together, eg if someone is trained someone else may provide the equipment so that skills can be used?

We wouldn't say the situation is perfect, there are those bottlenecks. The approach we have taken as a province, when training is to be done, it is bottom up, the district submits the names for a training, must be needs based, this office doesn't decide. Before a partner could say they will give us 20 slots, we discuss, this training is a priority, yes, so ZISSP has resources to train 20 in EmONC, ZISSP focuses on 3 districts, so this office writes the DMO, and says we will conduct this training, can you please recommend or nominate people to be trained from your district. Depending on your needs. DMO will select people from Health center, than we conduct training together with ZISSP and by and large we do things together, one training finished, HW goes back, now up to the DHO to ensure that people apply the skills they have learnt.

One of the challenges, training is not an end in and of itself one thing that needs to be clear is the HRH crisis. Sometimes even a training is challenged; you will be calling people for training, but maybe the HF doesn't have the number of staff, you may train the same people in a number

of areas, there is no sub for them so they can come to training, when they go back they are overwhelmed. If we were really to address at the start, before we talk of equipment is to address the number of health workers. Equipment; that's the path we are taking now, eg the EmONC equipment, ZISSP is involved but we also have the WB involved through RBF and also DFID, so this office provides that oversight and leadership.

We have an inventory of various pieces of equipment being supplied by various partners and where they are; the challenge sometimes starts at national level where some pieces of equipment may be provided for a center which has no power and the equipment which comes requires power. What we do than, we let the DMO use their discretion and they may move that equipment. Our recommendation has been if provincial level can be much more involved when it comes to planning especially when it comes to equipment and other logistics, instead of buying for a clinic that has no power, let's buy manual, when it comes to coordination we have tried as province to bring partners on board. Not perfect, but great efforts are being made. We can tell which partner is where, who is doing what. We do have periodic quarterly review meetings,. And we have ad hoc partner meetings in addition to scheduled meeting depending on issues. At provincial level I think we are coordinating well with partners, generally.

When we are doing performance assessments, CIDRZ, RIDERZ, CARE, JSI are all members of the team.

Has ZISSP been involved in this coordination?

Much more than for other partners, because ZISSP sits here at PHO. This methodology of placing officers at PHO brings synergy and easier coordination within the sector rather than if ZISSP has its own offices somewhere else within Chipata. There are some partners who are fully working in the health sector but have offices elsewhere. "The ZISSP methodology is the way to go."

9 a)	In what ways has coordination and synergy of HIV/AIDS, MNCH, Nutrition, FP, and Malaria services provided by stakeholders (MOH, USG, other donors, private sector health facilities, etc.) in ZISSP target districts been strengthened? Not asked
b)	Which of the above health services have been integrated in Health Facility at provincial level? Not asked
c)	Which of the above services have been integrated at Health Facility at district level? Not asked
d)	What are key challenges in integrating or coordinating health services across the 5 areas Not asked
10	In what way, if at all, has ZISPP facilitated coordinated planning at provincial, district, and/or HF level? Answered above

11	In what way, if at all, have multi-disciplinary clinical care teams strengthened coordination of services at provincial, district, and/or health facility level? Answered above
12 a) b) c)	What could ZISSP do in the remaining project period to further strengthen integration, coordination and/or synergies among other health services: At national level: At provincial level: At district level:
Section Five: Country Ownership	
13.	What is the perception of MOH and NMCC regarding ZISSP seconded staff's role in building capacity of Government of the Republic of Zambia (GRZ) counterparts to plan, design, implement, manage, monitor and evaluate health programs at the national, provincial and district levels? *ZISSP will be ending in next 2 years. Are there aspects of ZISSP support that you are picking up a as a province and taking charge of?* The beauty with ZISSP support is that for planning; these plans are made jointly by gov and ZISSP. In fact, the ZISSP support buys into MOH plans. Only thing is that Z is supplementing or complementing government efforts. If ZISSP was to go out what it means is that that gap may not be filled unless gov provides matching resources to fill the gap, but in terms of appropriating those areas of intervention they buy into what we have already agreed on as priorities. In terms of what we are picking up, all these areas are in our action plan.
14.	How would you assess the ZISSP seconded staff's role in building your colleagues' capacities to plan, design, implement, manage, monitor and evaluate health programs? Answered above
15.	How do you rate the specialists in these specified areas?
16	What are the most important issues for which the respective specialists are responsible that need to be addressed in the next two years? a) Clinical Care Specialist;

b) Management Specialist;

c) Community Health Coordinator Specialist;

What they are doing is already in our action plans; they are costed but in the annexes waiting for a partner to come and buy into them. If gov could increase allocation to sector yes we could pick up those activities that z has support but gov may not provide matching resources when that time comes. Hence the need for this partner phase out to be very gradual so that as support is phasing out gov is trying to take up that kind of support. I may not see it in the next year. We may not get there. We are increasing health budget gradually. Now it's 11.3% from about 8.7% so we hope maybe next year can also increase, but the demand in sector is so huge. Even if our budget allocation reached 12 or 13 % the gaps would remain.

What is most important for ZISSP to do between now and end of 2014?

Same areas, drive to ensure that clinical mentorship is institutionalized at all levels. Issues of QI, biggest criticism for health sector is that quality of health services could be better, so that area of needs to be expedited in implementation, not at expense of quality but to ensure that it becomes part of our day to day way to doing business. EmoNC – that' life and death, ZISSP has done a lot in training, equipment, other support, yes we need to see more and ensure that where possible we saturate our targeted areas. Coming to malaria, the IRS for EP was almost 100% supported by ZISSP; it's an expensive exercise to spray even 80% of households, so I don't think we are able to absorb that exercise this year. This year we need to start preparing and spraying around September. In this year's budget the monies there for IRS are little; again we need that help to continue and more CB in that area to enhance sustainability beyond partner support.

Also when it comes to community engagement, I think for smags we need to saturate to see impact. Also the issue of trainings for community structure; I know that ZISSP has been in 3 districts, our understanding was that there would be an end evaluation with potential for scaling up. what we've done so far, we need to scale up those interventions.

Then management and the ZMLA: we've trained people in leadership and management; this was like phase 1,just scratching the surface, a lot of people in leadership are not yet trained, what we have seen is that this training is worth going through, especially for people in hospitals, districts. We haven't even trained a quarter of people we want to train. Maybe we need to decentralize it to provincial level in terms of management of training, this is part of governance, you target leadership. The benefits are huge.

When you ask a question to say which areas of support, it's not an easy question, because ZISSP is buying in to gov activities and priorities, which are necessary, without Z, they will be done but not to the same scale. With Z they will be scaling up. All the areas of support are in priority areas. They are all resource based and not need based, so if money is scaled own, you just scale down level of implementation.

Section Six: Gender Integration

17.	To what extent have women been empowered to take action in support of health behaviors and interventions in ZISSP target districts? [*Participation as volunteers, Leadership roles in community groups, participation in community health planning, participation in distance radio learning program*]

Key informant Interview with Provincial and District Staff – MALARIA MANAGERS ONLY

INSTRUCTIONS

Thank you for taking time to participate in the ZISSP program evaluation interview. My name is_____ and I will be asking you some questions which will guide the interview process. The information provided will be handled with confidentiality. Please limit your response to specific activities related to the ZISSP program.

The questionnaire is focused on interventions against malaria. Both open and closed ended questions are included in the questionnaire. The closed ended questions have instructions for ticking the appropriate option, and providing descriptive information when requested to list and specify. You are required to provide descriptive information for all open ended questions.

Background information   **Date:**_____23 April 2013 _____**Level__Provincial**   **Souther Province**   **Title of Respondent** Acting PMO___ **Sex:** Male__X__ Female____   **Program Area (if applicable):**__Malaria_____   **Enumerators name:**_Deborah, Beatrice, Kumbutso _

Section One: Progress towards results	
1.	With reference to the table below, the changes between 2010 and 2012 are marginal, compared to the previous periods. What are your views on that? Re trends? In terms of IPT we use as proxy the number of ANC visits; we know that in terms of first visit we are in high 80th percentiles. Numbers progressively drops by 4th visits. They are supposed to receive 3 doses, but we know that they are getting first dose. For first dose numbers would be good. Mr. K has put data together for this. Are you doing DOTS for IPT? When women are given pill? Yes.
2.	It is generally expected for most phenomenon that progression would be slow in the

	top levels. Is that something you were expecting in IRS and IPT? For IRS, whole province is now under IRS, first started with 3 districts, bumped up to 5 or 6, now the whole province. We can see that the incidence rate in province in general has dropped over past 5 years. We still have logistics issues, sometimes have stock outs. We find that you may still be recording cases of clinical malaria, sometimes distorts data. In 3 districts (Gwembe, Sinazongwe and Siafonga) we still have malaria as a major problem. A lot of positive RDTs still. They were the last districts to be brought on board for the IRS. Through NMCC certain districts are doing a test and treat procedure. 3 or 4 districts. So you find an index case and then do this? Yes. Soing this in Kazungula, Gwembe, Sinazongwe.
3.	What are the positives in behavior change communication activities related to malaria, if any? ZISSP has come up with guidelines and trainings, although we've distributed a lot of nets, people still don't sleep under them: without solid evidence difficult to say whether behaviors are changing. If we go by the incidence rate in past 5 years, also malaria associated mortality, we can speculate that more people are sleeping under nets. We've still got cases where it has been reported that they are being used for fishing. Are still in plastic bags. *Do you think RDT is easier to manage? For logistics distribution, hard to judge end result. Can see that households has a net or doesn't. People can go door to door, record GPS markings. Can see whether all buildings have been covered.* *ZISSP has put a lot of support into GIS control. They told us they record the buildings they have been sprayed. Is this really what is happening on the ground?* Each district has got its targets, as reports come in, we do a final compilation by district of the percentages of households that have been covered for a provincial picture that is forwarded to NMCC. Paperbased report. *With that kind of system, it works well in the initial stages of your program.* In initial 3 districts, they are using the initial geocoding system. *Have you seen this system?* No, but have seen some of the presentations that demonstrate this. But for districts outside ZISSP. Seems not ZISSP's doing.
4.	In IRS which is an area of focus by ZISSP, what are the challenges in attaining higher near universal coverage?
5.	In IPT which is an area of focus by ZISSP, what are the challenges in attaining higher near universal coverage?

Benchmarking Malaria trends in the general population of Zambia						
Indicator	**2001-2002 Zambia Demographic and Health Survey**	**2006 Malaria Indicator Survey**	**2007 Zambia Demographic and Health Survey**	**2008 Malaria Indicator Survey**	**2010 Malaria indicator Survey**	**2012 Malaria indicator Survey**
Percentage of households receiving IRS in the previous 12 months among all households	N/A	10	N/A-	15	23	25
Percentage of children 0-59 months who slept under an ITN the previous night	7	24	29	41	50	57
Percentage of pregnant women who slept under an ITN the previous night	8	25	33	43	46	58
Percentage of household members who slept under an ITN the previous night	N/A	19	N/A	34	42	49
Percentage of pregnant women who took any preventive antimalarial drug during pregnancy	36	85	87	88	89	88
Percentage of pregnant women who received 2	N/A	59	66	66	70	72

doses of intermittent preventive treatment during pregnancy						
Percentage of children ages 0-59 months with severe anaemia (Hb < 8 g/dl)	N/A	14	N/A	4	9	6
Percentage of children ages 0-59 months with malaria parasitaemia	N/A	22	N/A	10	16	14
Percentage of women 15-19 years who recognise fever as one of the symptoms of malaria	N/A	65	N/A	71	75	78
Percentage of women ages 15-49 years who reported mosquito bites as a cause of malaria	N/A	80	N/A	85	85	89
Percentage of women ages 15-49 years who reported mosquito nets as a prevention method	N/A	78	N/A	81	82	86

Key informant Interview with Provincial and District Staff - Comprehensive

INSTRUCTIONS

Thank you for taking time to participate in the ZISSP program evaluation interview. My name is_____ and I will be asking you some questions which will guide the interview process. The information provided will be handled with confidentiality.

The questionnaire comprises three sections; background, capacity building and human resources for health. Both open and closed ended questions are included in the questionnaire. The closed ended questions have instructions for ticking the appropriate option, and providing descriptive information when requested to list and specify. You are required to provide descriptive information for all open ended questions

Section One: Background information

Date:_____23 April_____
Province____Choma_____

Title of Respondent _Acting PMO_____ **Sex:** Male_XX___ Female_____

Program Area (if applicable):_____

Enumerators name:_Beatrice, Kumbutso, Deborah__

Section one: Progress towards results	
1.	In your view, has there been any progress in ZISPP supported districts in the following areas:
h)	***Training:*** Have had trainings in QI, nutrition, mentorship for clinical care team, also trainings at community level: Safe Motherhood, orientation of NHCs.
i)	***Developing training manuals/resources:*** Initially not really involved in this. Maybe happened at Central level. Don't develop materials at provincial level. Sometimes we are invited to meet to contribute.
j)	***Developing policies, strategies and guidelines***:
k)	***Conducting Research and assessments:*** Lots of materials, can't easily tell which are ZISSP per se, but so many guidelines come down: QI, WHO for TB, ART, PMTCT, nutrition, IMCI, misoprostol, almost anything. Hasn't yet seen the Adolescent Health Communication Strategy. ZISSP involved Kalomo, Saving Mothers Giving Life, integral part of that initiative. Probably research coming out of that (ASK!) personally hasn't been involved in any assessments. Know that ZISSP has supported bi annual performance assessment in fact

	the Z staff join us and we get financial support for these meetings.
l)	***Systems development and sound strategic approaches:*** ZISSP in the 4 districts have been important ?? with communities, with health facilities through work at community level. One of MOH weaknesses has been that, not able to link community properly to health facilities. Our job is really passively waiting for people to come to facilities to seek services, revived some community groups such as the NHCs that have been inactive, the SMAGS, other community work with Z support has helped us to link HF with communities better. We tried to integrate the services as much as possible; a lot of work has gone into trying to kick start clinical care teams for QI of case management. Still have a long way to go. Have teams in the districts on the ground, need more mentoring supervision. Also have a lot of QI processes and trainings going on right now. Trying to mske sure we have QA for health facilities.
m)	Community mobilization for maternal and neonatal outcomes. Yes. Of course we still need a lot of SMAGs to be reactivated and NHCs as well, but for those that have been trained, we can for example see preliminary results in some districts. Have reofrd improvement in facility deliveries. Women who are dying in childbirth, e.g. in Kalomo, results show that MM is coming down. The preliminary results are showing that in facilities where SMAG was started earlier, those are the ones experiencing higher increase in # of facility deliveries. Same facilities that have also experience reduction in # of women that are dying. Due to pregnancy complications. The data that we have is from Kalomo, but may not have data to demonstrate time of SMAG starting to time of decline in maternal mortality or increase in institutional deliveries. Not only the SMAGs that are being trained, whole host of interventions are happening to reduce maternal mortality and improve outcomes. May not just be the fact that SMAGS are active, although it's an important aspect. Transport has been improved, communication has been improved, more midwives added at facilities - PMO has employed them through cooperative agreement with CDC.
n)	Other, specify: No. --- ---
2	In your view, have ZISSP activities affected any changes in the following areas: *Coordination of key stakeholders; ongoing clinical mentoring, Supportive supervision, Providing human resources through seconded expert staff and support of retention scheme, Providing financial resources, Participation and provision of TA support in national, provincial and district MOH planning and budgeting activities, Implementation of grants program/capacity building of grantees in grants management and organizational development?* Coordination of key stakeholders. As an office we are dealing with a lot of partners for different program areas. Even before the coming in of ZISSP, have technical committee meetings with all partners, even before ZISSP, so ZISSP just joined in with officers seconded to us to be part of that. We plan together with our partners, sit down and

	compare notes, open communication through emails and phone calls. Problem is that we can't see ZISSP separate; the 3 staff just blend into what we do. Difficult to say this is where ZISSP per se has contributed. Has ZISSP partnered strongly with other partners? In Kalomo yes, working with CDC, and Boston University/ZCHARD? Big project at central statistical office/University of Zambia, CHAI. We have a cooperative agreement with CDC, get direct funding, so yes it is the PMO getting support from CDC. WE can give you baseline information. What is CSO doing? Have a presentation that covers past 2 years. CSO was involved in enumeration of areas where project would be implemented. Verbal autopsies? We had a clinical care team system before ZISSP, but Dr. Nancy is really sort of providing direct support to clinical care teams in the districts, in terms of finances for them to hold meetings and carry out activities, also providing technical backstopping. Contributing toward maternal death reviews? Simon as CCS was away at school for some time, in his absence Nancy's office used to collect maternal death data at provincial level, coordinate meetings, making sure maternal death review meetings are held. As PMO in the process of trying to improve maternal death reviews, are moving towards the surveillance for maternal death review. (ASK more about this.)
Section two: Capacity Building	
3	What ZISSP strategies or activities are you aware of that have helped to strengthen community participation in improving health? **[Prompt for SMAGs, NHCs, HCAC]**
4.	Based on your experiences or observations, how have ZISSP community focused activities addressed gender issues (e.g. household decision making, gender imbalances among health workers or volunteers), if at all?
5	Based on your experience or observations, do you believe that quality of care at community level has improved? If so, what groups of community members have benefited most from ZISSP activities? Are there still groups that are yet to be reached? Only problem is that we do not really have indicators that would give us information about whether things are improving at community level. Only thing we can do is look at #s of people who have been trained on the ground. Maybe speculate with some improvements seeing at HF level, e.g. increased facility delivery levels where SMAGs and HNCs have been trained, reactivated. To answer some of these questions you need a small survey, concrete evidence, find ways of attributing certain activities to ZISSP.

Section three: *Human Resources for Health:*	
6.	In what ways has ZISSP helped to attract and retain health workers in rural positions? Know that for medical doctors, in most rural districts, they benefit from the retention scheme. They do get a top up of money to motivate them to stay and work in rural areas. Not too sure if there are other conditions. I was under the scheme but before ZISSP came, it was HSSP, wasn't only top up of salary but had some improvements to my house, renovations,
7	In your opinion this context do you have an opinion about any benefits of the following specific capacity-building programs promoted by ZISSP:
8	What are the most important issues related to attracting and retaining health workers in rural positions that need to be addressed in the next two years? Monetary motivation is important. Housing for health workers in rural areas is a serious problem. Maybe can be looked at.
Section Four: Coordination and Integration	
9 a)	In what ways has coordination and synergy of HIV/AIDS, MNCH, Nutrition, FP, and Malaria services provided by stakeholders (MOH, USG, other donors, private sector health facilities, etc.) in ZISSP target districts been strengthened?
b)	Which of the above health services have been integrated in Health Facility at provincial level? Our mandate is to give technical support to the facilities, so if I am going to give technical support in say TB, not going to go alone, probably going to go with someone from other departments (talking about clinical mentoring). Will not only look at one program areas, will look at all. Not only through clinical teams but in all technical support. TSS is done by a multidisciplinary team – clinical care team. Move to facility level. Yes to some extent. We try as much as possible to integrate services and make sure these programs are working together. At facility level, you find that you have a facility with one or two staff, the integration starts from there, they are doing all. There are specific integrations that we have tried, e.g. MCH and ART in certain facilities. Essentially we try to make sure that all programs are integrated. FP integrated with MCH. Malaria too, we get IPT through ANC, health education through MCH and under five clinics, health education and distribution of ITNs. Added question about EmONC in particular. ZISSP has been involved in training. As far as they have gone. Doesn't think they have procured equipment. CDC through cooperative agreement provides support for EmONC equipment, have also done trainings, have also employed midwives.

c)	Which of the above services have been integrated at Health Facility at district level?
d)	What are key challenges in integrating or coordinating health services across the 5 areas
10	In what way, if at all, has ZISPP facilitated coordinated planning at provincial, district, and/or HF level?
11	In what way, if at all, have multi-disciplinary clinical care teams strengthened coordination of services at provincial, district, and/or health facility level?
12 a) b) c)	What could ZISSP do in the remaining project period to further strengthen integration, coordination and/or synergies among other health services: At national level: At provincial level: At district level:
Section Five: Country Ownership	
13.	What is the perception of this office regarding ZISSP seconded staff's role in building capacity of Government of the Republic of Zambia (GRZ) counterparts to plan, design, implement, manage, monitor and evaluate health programs at the national, provincial and district levels? Essentially, we need all the help we can get in terms of staffing and technical people, and the 3 have been an important resource for us. Have really blended in and become part of the team. Having said that, maybe if we could have a bit more transparency in terms of some of the activities that are planned, some of the funding that comes through from ZISSP, that could be worked out internally here at this office. We find that sometimes there is a bit of communication breakdown, if that is addressed everything should fall

	into place.
14.	How would you assess the ZISSP seconded staff's role in building your colleagues' capacities to plan, design, implement, manage, monitor and evaluate health programs? Especially at district level, maybe not so much at provincial level because our provincial clinical care team are experts, are at a higher level than colleagues from ZISSP. We've got consultants from Livingston General Hospital, but at district level yes the hands on training yes.
15.	How do you rate the specialists in these specified areas?
16	What are the most important issues for which the respective specialists are responsible that need to be addressed in the next two years? d) Clinical Care Specialist; e) Management Specialist; f) Community Health Coordinator Specialist;
Section Six: Gender Integration	
17.	To what extent have women been empowered to take action in support of health behaviors and interventions in ZISSP target districts? [*Participation as volunteers, Leadership roles in community groups, participation in community health planning, participation in distance radio learning program*] On that one I'm a little bit blank. I know that women have been involved in the training at community and facility level. Not too sure whether there was a specific drive towards may be training more women than men, for example. In terms of people trained have had quite a number of women, at both levels.

Key informant Interview with Provincial and District Staff - Comprehensive

INSTRUCTIONS

Thank you for taking time to participate in the ZISSP program evaluation interview. My name is_____ and I will be asking you some questions which will guide the interview process. The information provided will be handled with confidentiality.

The questionnaire comprises three sections; background, capacity building and human resources for health. Both open and closed ended questions are included in the questionnaire. The closed ended questions have instructions for ticking the appropriate option, and providing descriptive information when requested to list and specify. You are required to provide descriptive information for all open ended questions

Section One: Background information

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Province____Choma_____

Title of Respondent _Acting PMO_____ **Sex:** Male_XX___ Female_____

Program Area (if applicable):_____

Enumerators name:_Beatrice, Kumbutso, Deborah__

Section one: Progress towards results	
1.	In your view, has there been any progress in ZISPP supported districts in the following areas:
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p)	***Developing training manuals/resources:*** Initially not really involved in this. Maybe happened at Central level. Don't develop materials at provincial level. Sometimes we are invited to meet to contribute.
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15.	How do you rate the specialists in these specified areas?
16	What are the most important issues for which the respective specialists are responsible that need to be addressed in the next two years? g) Clinical Care Specialist; h) Management Specialist; i) Community Health Coordinator Specialist;
Section Six: Gender Integration	
17.	To what extent have women been empowered to take action in support of health behaviors and interventions in ZISSP target districts? [*Participation as volunteers, Leadership roles in community groups, participation in community health planning, participation in distance radio learning program*] On that one I'm a little bit lbank. I know that women have been involved in the training bot at community and faclaity level. Not too sure whether there was a specific drive towards maybe training more women than men, for example. In term so fpoepole trained have had quite a number of women, at both levels.

Choma Follow Up Notes With Seconded Staff And MOH Master Trainer On Model Sites And IMCI, 23 April

Master trainer: They are training 24 nurses, EHTs and Cos from HF in 3 districts: Gwembe, Sinazongwe and Kalomo, all ZISSP Districts. ZISSP is providing financial support for training. This is first training in Southern province for IMCI. SP has a low saturation for community health workers trained in IMCI. (not sure why he said CHW here, rather than HW). They

intend to train more. They want to include CHAs who are not yet trained in ICMI. Although their course does include ICCM. Why aren't there any CHAS in this training?

Nancy: ZISSP is trying to strengthen health systems and improve quality of care, trained health workers will lead to better quality of services and better health outcomes.

MT: The third objective of IMCI links to community, encourages community participation to promote early care seeking, good feeding practices.

Zambia has a National Strategic Plan for IMCI that aligns with the National Health Strategic Plan. Request a copy of this document?

For this training, there will be follow up 4 to 6 weeks after, this is the second component of the training, will visit training participants where they work. He is also while here having update meetings with the training facilitators.

The ICMI curriculum for community health workers is different. They get 6 weeks training, also in ICCM, focus on 4 diseases, pneumonia, diarrhea, malnutrition, malaria. Process of training volunteers helps community have sense of ownership for all programs. Supervision of chw done by nearest HF. Intention is to strengthen structures, linkages, referrals.

What %age of hw and chw have been trained in IMCI? The target is 80%; for SP coverage is low for ICCM, doesn't have data for ICMI. The numbers of hw per district are in the HR registers. But SP doesn't have actual numbers for each district (??). SP is just now in process of retrieving HMIS data; the system was sabotaged by disgruntled workers, is being reconstituted.

Other IPs are supporting master trainers but not in ZISSP districts. Where ZISSP districts have reached saturation levels for IMCI trained HWs, the national map is green. They are using proxy indicators since it's expensive to do IMCI. Ask for the 2008 IMCI facility health survey.

For hw trained coverage Gwembe is at 6%, Kalomo 35%, Sinazongwe 10% (toward 80%). But there is no common denominator, depends on # of hw at each facility, and there may be only one or two.

MOH is now adding IMCI to pre service institutions, already completed for Cos, and 50% of nursing schools are implementing the training. Nurse tutors must become certified before they can train the curriculum. Using ICAT – ask to see the course, see if it's been adapted for Zambia? The computer work then must be aligned to practicals, they are moving toward saturation for pre service students. MOH has bought 22 computers for one institution, students can use their own laptops.

In SP 30 CHWs have been trained in ICCM in Kalomo, 50 in Sinazongowe. The real indicator is increase in early care and decrease in child mortality. They need to strengthen supervision for CHWs, guide them in proper use of tools. Need to do more orientation for supervisors.

Where CARE is working have reached saturation levels for training and can see differences in quality of care. Talk with CARE about this?

During planning launches MoH develops updates for managers in various fields, including IMCI. Provides global evidence for support of guidelines. Hard for MOH central staff to move everywhere; ZISSP comes at HF level to push agenda.

How many master trainers? Less than 15 at national level, based in different provinces. He is only full time trainer for IMCI. There are national facilitators, then master trainers. 2/3 of trainers in every province are certified master trainers. They train the training facilitators. There are 2 groups of trainers in IMCI. Training is 8 days long.

How is supply of related drugs? There are at times supply chain problems at national level. SP has 2 systems for supplying drugs, the problematic one is doing R&Rs. EMLIP was a pilot, had many problems, requests were okay but responses not. They trained many districts in this method, still doing, there is poor coordination with medical stores. Things have changed, now reverting back to old system of kits being delivered to health centers.

For IMCI drugs, major challenge was in kits, would put capsule formulation not appropriate for children, have fixed this. Trying everything, challenge to see how HC staff will calculate quantities needed by individual communities. Need help with allocation. WHO is working on this.

Want to revamp assembly of HW kits. RDTs are controlled by NMCC. Some HFs don't have them.

Who is doing forecasting? Districts do this during planning.

The IMCI database and the HR register show HWs to be trained for IMCI. The targets are in the NHSP and also the IMCI SP.

Districts have monthly updated returns, feed into the HR registers, provinces supposed to use these to do monthly reports.

Maureen: most collaboration in SP for Z has been with CDC for data management trainings, have done a lot of work together. BU is involved with SMGL, worked with them in initial phase, since Z hired the national coordinator. HQual has done QI in Ny?

MODEL SITES

Are part of the ZISSP QI strategy – being used to prove QI can work and show results. MOH at central level picked 5 key indicators (we have this in our orientation notes and in ARs); Then each province picked 5 model sites that met these criteria:

Accessible year round, HIV and ART services, a minimum of 3 staff, a hospital with maternal and child mortality data.

In Kalomo, Nancy the second CCS picked 3 health centers: Namwianga, Mawaya and Kanchele. We visited Namwianga, which is nicely built mission hospital with a strong SMAG group operating there.

When she or the team, not sure which, goes for TSS, they give this for QI, found that Namwianga had come up with a list of quality indicators. We visited this site and saw their

QI folder, very well prepared, they are following the procedures taught in the ZISSP supported QI training. We took notes on what the folder contained.

With Mawaya, there has been little follow up since training.

With Kanchele, there was only one person working when team visited, no HR to build QI. So picked a new site in Gwembe.

How this is supposed to work is the model sites will have functioning QI committees that include a community person. They should be able by developing and carrying out a QI plan that QI does impvoed quality of care.

The two hospitals picked for Southern Province were Livingstone and Gwembe (total of 3 health centers and 2 hospitals). They do have functioning QI committees and she has the minutes (she may have sent us some, if not we should ask for them). QI committees are supposed to review HF data and identify quality issues for clinical mentoring teams to address and provide mentorship.

Prior to this effort, in SP the only QI interventions were for laboratory services. Also CIDRZ was doing something for ART clinics, had a QI checklist. CIDRZ the only other group doing QI in SP. So they developed a one page tool to be jointly used. They are hoping to pilot this in several facilities to identify quality issues quickly. They are supposed to use it monthly. Will begin to use in May.

CIDRZ has completed a training on how to use the tool. CIDRZ and ZISSP must agree on how long to pilot its use before assessing it. Nancy has forwarded it to the team leader Dr. Daka, along with clinical mentoring tools.

Question to Nancy re progress toward sustainability, whether ZISSP has an exit strategy or plan to hand over pieces of its support to the province between now and project end.

In 2011, the CCS was providing field transport (for mentoring?) Then in 2012, gave fuel but not always directly involved. This year not that much funding so asking district to take up activity. But since January have only received one grant from central level and should have received four.

Choma and LIvinstone have program where program officers must do something out of office every week, so they walk to nearby HFs for mentoring, don't need outside budget for this. Maybe ZISSP can piggyback on that and add some QI activities during these visits.Also province and districts do have clinical mentoring, so ZISSP not funding all of this. She suggests we ask to see the QI folders at the HFs.

CIDRZ was managing server ART sites, ten sopped completely; that was a disaster.

Chongwe One-on-one Interview with DHO CCO Trained by ZISSP

District: Chongwe District Health Office
Province: Lusaka
Name: Mr. Chepa Chooze, CCS

ZISSP training participated in

1. Clinical mentoring
2. Quality Improvement
3. Annual Performance Appraisal System (APAS)
4. Malaria Case management

New skills gained: Yes in clinical mentoring, QI – haven been able to mentor others, APAS – helped him to identify be accountable for his roles and responsibilities and malaria case management – skills in supervisory role.

Other skills gained: Have also developed his M&E skill

Further capacity required:

- ZISSP/DHO needs to provide more support on QI and clinical mentoring. Training is done but now needs to intensify QI and clinical mentoring visits at health center level. As this is core business of the health care system.
- Put more effort in LTFP training and service provision. Have very few service providers in the district.
- IRS – ZISSP has been supporting this intervention, but needs to add other interventions such as laviciding – using chemicals in ponds to reduce the population of mosquitoes. This helped a lot many years ago under a different project. The IRS intervention is being provided as a package – training, management of chemicals, management of human resources -, use of community members who apply and are taken through an interview process and are trained before they are allowed to start spraying. Gender balancing has been considered in this program. This program is a continuation from HSSP and changes have been seen in the past 4 years – saw a quick drop in the number of malaria cases, But now seeing an up-swing of malaria cases reason for this not yet confirmed, but there are assumptions related to the use of DDT which was stopped by government and the introduction of new chemicals. Have used about 3 types of chemicals now. The chemicals are supplied through GRZ supply system.
- APAS – Training done in December last year. No assessment have been conducted yet.

Strengthening community participation:

- Consider extending to other communities/facilities – if possible all the 28 health facilities. Yes provision of quality services at community level is being seen, especially in communities where the facility has embraced the community participation concept such as Kanakatapa, Katoba and Chinyunyu.
- Those trained have also understood what demands to make that benefit the community and should now be supported to review achievement of targets at least twice a year. These meetings will help them know that they are being monitored and that they are monitoring themselves.

BCC training was conducted and the health promotion focal point person is one those that were trained. ZISSP works with other partners at community level, such as Child Fund,

World Vision, PCI/Pop Council Compact, CIDRZ – PMTCT, ART, and BHOMA – better health options for monitoring and assessments – working with health facilities and conduct follow at home. ZISSP attribution is possible, partners work in different sites. World-vision and Child Fund are child focused, PCI compact is specific to HIV prevention, while ZISSP takes care of the whole district in QI, Clinical mentoring, malaria case management and APAS and for community based activities work in sites not covered by the other partners.

Issues to be addressed in the next 2 years:

- It is good that the SMAG training has started, and scale up is inevitable. Financial and technical Support is still required for training and ongoing supervision support
- While TBAs roles have changed and are no longer trained by GRZ, this is a groups that naturally occurs and will always be there, with or without government support. I foresee a situation 10 years from now where we will continue to have TBAs but untrained.
- Need a buffer for volunteers to take into account attrition. Not so sure how the CHA program will turn out to be. Very few were about 12were selected in Chongwe district and are undergoing training right now.
- IMCI training cover management of fever and yet health workers are still comprehensively trained in Malaria where as diarrhea has remained as a topic under IMCI yet it is a very big a big problem in children. ZISSP should consider pushing this higher up on the agenda – where possible provide additional intense training.
- New training is inevitable as old staff keep on moving to other sites or districts and new staff keep on joining the district. This is how the ART program has been sustained – continuous training.

Generally, ZISSP support is highly appreciated by the DHO and support has always been provided when requested. ZISSP has a broader approach to providing support and are very good at accommodating and addressing gaps as they arise unlike other partners who only operate within specified mandates. ZISSP has made the PHO alive. They stick to schedules and plans.

Sustainability: Have started addressing by way of cost sharing in activity implementation. For example, ZSSP could fund venue and meals for training, while the district funds allowances or fuel etc.

Chongwe One-On-One Interview With DHO MCH Coordinator Trained As SMAG District Trainer

Had an interview with Jean Miti, DHO MCH Coordinator. Trained as a district SMAG trainer in April 2013 in Livingstone. Interview conducted at a community-based SMAG training

Training Topics: The training covered community meetings on women's problems during pregnancy, after delivery, and baby problems during and after birth; how to prevent these problems, facilitation skills which focused on participatory methodologies including demonstrations, role plays, experience sharing and plenary discussions.

New skills acquired: Use of local language during training, how to interact with other people – no note taking, only discussions and use of pictures.

Added Knowledge: use of sugar salt solution at community level during labor and when bleeding, how to make client comfortable and how to use plastic papers when gloves are not available.

Practice: Now conducting training. She feels she now has the capacity and confidence to train others.

Follow up evaluation: Plans to conduct quarterly supervisory visits in collaboration with the other trainers.

ZISSP support: ZISSP has provided funds for meals, facilitator allowances, participant transport refunds, T-shirts and facilitator and participant training manuals. The facilitators were given ample time to prepare for this training – were informed about the training the TOT in Livingstone.

Challenges: Volunteers were identified to do the cooking, but unfortunately, by day 2 only 1 person turned up and this could have attributed to no payment made for the cooking. Meals were delayed and subsequently the sessions as well. The food budget did not include the team doing the cooking and expectations were that they would be given some food as well. The selection criteria used by NHCs was to take participants whose communities are very far from health facilities. The training logistics did not take into consideration the long distances resulting in participants coming in late for training and reaching home very late. Three participants from the furthest areas opted to stay at the venue, but logistically, there was no money for supper and breakfast.

Recommendations

- NHC's selection criteria of participants are good, but issues of distance and accommodation should have been looked into.
- Although the training is participatory/pictorial, a lot of discussions that are providing learn are taking place, and participants feel it better they are provided with pens and note books for notes as these could be used as reference notes back in the community.
- Volunteer cooks' payment not budgeted before posing attrition challenges. This should be considered in sub-sequent training.
- The training has no session that allows participants to practice facilitation skills. This should be included in future training.

Summary of ZISSP Support

Chongwe One-On-One Interview With MOH Staff Trained By ZISSP

Facility: Kanakatapa Rural Health Center

Name: Cristabal Changala, General Nurse

Met with a general nurse trained in EmONC, who completed training last week. The training was for 20 days.

New skills: Have gained new skills in manual removal of the placenta, breech delivery, MVA- first time learning about this, and vacuum extraction – also first time learning about this.

How She Hopes to use new skills: With the assistance of and mentorship by the midwife already trained in EmONC under HSSP and by using the manuals, presentation graphics and participant guide, she will be able to use the skills she has gained. Although there is no MVA equipment at the health center, she will once in a while go to practice at Chongwe district Hospital.

Other skills gained: These include shouting for help – how to debrief support staff such as maids and guards etc. and use them during an emergency; skill to manage an emergency, skill in data collection, management and use.

Changes she would like to make: Being a general nurse, she will depend on the midwife for mentorship

ZHWRS: She has not heard much about the scheme and she is not registered on it as their facility is not eligible

Community Volunteers:

- Work with CHWs.
- TBAs – assist with ANC – taking vital signs such as weight, height, blood pressure, urinalysis and escort pregnant women in labor to the health facility.
- IYCN volunteers who give talks on nutrition and assist with cooking demonstrations using locally available foods. They also conduct under-five GMP. Not so sure who trained them.
- HCAC –not yet trained by ZISSP but participate in planning health center planning.

Issues to be addressed by ZISSP in the next 2 years: Provide EmONC equipment, conduct additional training e.g. in IMCI. Only one EHT was trained a long time ago.

Chongwe One-On-One Interview With Trained Staff

District: Chongwe

Facility: Chalimbana RHC

Province: Lusaka

Met with Mrs. Kelita Chifuchi, a nurse midwife, who recently underwent EmONC training (last week). she indicated this was a 21 days training comprising a week of theory, 2nd week of classroom practice, and 3rd week of hospital and health center practice. The training was competence based covering topics such as: adult and neonatal resuscitation, intubation, MVA, breech delivery, shoulder distortion, cervical repair – episiotomy and repair, use of partograph , active management of 3rd stage of labor, manual removal of placenta, post

abortion care and management of bleeding and shock. They use a training guide to practice the new skills – evaluated by fellow participants and finally were evaluated by facilitators.

New Skill Gained and How I Plan to Use the Skills: "I am excited about this training, and have decided to straight away begin to put my new skills in practice. I have some equipment in the clinic which I was not using because I had no skill in using them " For example the : Resuscitaire which was provided by CHAZ 2 years ago, vacuum extractor also provided by CHAZ, Ambu bag provided by CIDRZ, Autoclave donated by Koica Japan in January and Rotator for RPR provided by CIDRZ.

Today is my first day at work following the training, and I have already identified a room to place the resuscitaire and autoclave. I checked on the instruments and confirmed I have enough to use to provide basic EmONC services. I am ready to start providing the services. I now know how to use magnesium sulphate for management of enclampsia. I had this drug but it expired without being used because I did not even know how to dilute the drug. I am now motivated to use the partograph more than before.

The facility has an MDR committee but she will also spearhead formation of infection prevention (IP) committee to improve infection prevention at the health center. She hopes debrief to other staff and thereafter to mentor the other nurses who are non-midwives. Plans to place an additional bed in the labor room, which is already available to be used for MVA.

Guidelines: I have guidelines e.g. the manuals provided during training, charts on management of 3rd stage of labor, new born resuscitation, management of pregnancy and post-partum, danger signs poster, prevention of excessive bleeding after birth, ANC birth plan, birth preparedness and danger signs. These were clearly displayed around the maternity unit rooms and were developed by different partners such as ZISSP, CIDRZ, MOH, CHS and SFH.

Other training received for ZISSP: She is trained in IMCI and uses this skill when working at the OPD. She has developed an IMCI file where duplicates of management notes written on plain papers are filed. This is because patients use note books which they carry home after being attended too. She has done this I order to track the IMCI work and case load for reporting.

Community Links: She also hopes to work very closely with the group of SMAGS that were trained by funding from the first lady's office and together they should be able to reduce maternal mortality in the area.

ZHWRS: She is not under the scheme as the facility is not eligible.

Required Support: She will need support in provision of buckets for IP, a constant supply of Jik solution and assistance with calculation of the 0.5% of the Chlorine tablets and the water parts required to make the required solution for disinfecting. The chlorine tablets are available.

Chongwe One-On-One DHO Staff Trained In IMCI By ZISSP

Facility: Katoba RHC

District: Chongwe
Province: Lusaka

Interviewed Humphrey Chileshe, EHT and in-charge of the facility. He was trained in IMCI last year by ZISSP.

New Skills: The new skills have helped him a lot for example, before training, "I could only take history and treat. But now I am able to do physical examination, identify danger signs and give appropriate treatment. I also now able to apply this skill even on adult patients

HRH: Not on the scheme but have heard about it.

Community participation: Two NHC members have been trained from 2 communities. Their zones have shown improvements in developing plans, reporting, implementing plans and are meeting regularly. The link between community and health center has become stronger. They conduct community sensitization and we are seeing more individuals accessing services. E.g. during child health weeks, more child are brought. The facility however, still has low facility deliveries. No SMAGS have been trained. The training is scheduled for next week Monday May 13.

Recommendations:

- ZISSP should train and scale up the work of SMAGS
- Increase community sensitization and drama messages on maternal health and benefits of delivering at a health facility
- Increase staffing levels through the retention scheme. Currently have three staff; EHT, EN and EM
- Increase the number of trained NHCs
- The only motorbike has broken down and this has slowed down outreach activities. Support in the area of transport is a key need.

Health Facility Capacity

Staffing and training: Have three staff, only one was on duty at the time of the visit and none trained in LTFP and EmONC. Only 2 staff trained in IMCI by ZISSP.

Community Volunteers: Work with several community volunteers and only 2 NHCs have undergone ZISSP training.

- CHWs conduct home management of malaria and treat other diseases – supported by NMCC.
- NHCs assist with community planning and sensitization in various health aspects including water and sanitation
- TBAS escort mothers to health centers and conduct health education
- Clinical supporters assist with data entry
- TB treatment supporters conduct home visits for adherence support and supervise DOTs
- Lay counselors conduct HIV counseling and testing

Service Delivery

Child health: IMCI –immunizations – 2 staff trained, EHT and EN. No CGMP and IYCN activities are provided. IMCI guidelines seen and is being used.

Family planning: LTFP not provided at this facility – on oral, injectable and condoms are provided. No ZISSP training in LTFP. MOH FP counseling guidelines seen. No CBDs. 1 nurse is trained in FP – but from nursing school.

EmONC: No ZISSP training yet. The EM was trained by CIDRZ and she provides basic EmONC services and refers for comprehensive EmONC services. No guidelines seen – midwife not at facility at the time of the visit.

SMAGS: No SMAGs trained yet. Training scheduled for the following week.

Transportation: Three Zam Ambulances are used, provided by CRDRZ EmONC project.

MWH: Have a maternal waiting on with an average of 3-5 pregnant women utilizing the home.

MDR: Not sure if DHO has a MDR committee. The facility investigates the death at community and facility level and prepares a report which is sent to Chongwe DHO.

Malaria: One nurse was currently trained in Malaria but not sure if it was by ZISSP. IPT is provided during ANC, No IRS has been conducted this year, only last year. Copy of MOH diagnosis and treatment of malaria guidelines seen.

Key informant Interview with Provincial and District Staff – Comprehensive - Chongwe

INSTRUCTIONS

Thank you for taking time to participate in the ZISSP program evaluation interview. My name is_____ and I will be asking you some questions which will guide the interview process. The information provided will be handled with confidentiality.

The questionnaire comprises three sections; background, capacity building and human resources for health. Both open and closed ended questions are included in the questionnaire. The closed ended questions have instructions for ticking the appropriate option, and providing descriptive information when requested to list and specify. You are required to provide descriptive information for all open ended questions

Section One: Background information

Date:_06 May_ **District:**_Chongwe and Rafunsa (new district, split off from Chongwe)

Title of Respondent _Mr. Chongo, CCO and Acting DMO and Dr. Siyolwe **Sex:** Male X Female X

Program Area (if applicable):

Enumerators name: Beatrice, Deborah, Amon

Section one: Progress towards results	
1.	In your view, has there been any progress in ZISPP supported districts in the following areas:
v)	***Training:***
w)	***Developing training manuals/resources:***
x)	***Developing policies, strategies and guidelines***: ----------
y)	***Conducting Research and assessments:*** Yes, ZISSP conducted a baseline assessment, actually a mapping exercise prior to training of SMAGs. They were finding out number of women who came for first ANC visit and # of women who died due to pregnancy related causes and # of women who received 2nd and 3rd dose of Fancida, there were several indicators. Basically the maternal indicators, also how much is the community participation in terms of safe motherhood.
z)	***Systems development and sound strategic approaches:*** There are many: examples, malaria case management, confusion of Fancida vs Coartem, what should you do in complicated cases? The coming of ZISSP supported us in training our staff and changed perceptions by our providers as to how to manage malaria case, not only giving information, also leaving guidelines. A very nice training very much appreciated. Around September 2011. Was any system developed from this training? What has been left in place apart from technical training? In terms of documentation, we rely on existing system, how data is collected. Used to have confusion on clinical and confirmed malaria, now after training we make sure that suspected malaria undergoes confirmatory tests then give treatment. ZISSP has strengthened the data well as the treatment protocol. Now using both RDT and microscopy. Difficult for this area thought because only 5 HF have a microscope.
aa)	Community mobilization for maternal and neonatal outcomes. For community mobilization, we have noticed that after the training this has been one of weakest parts in two districts, there as problems with understanding how government

	operates, the coming of ZISSP brought a link between community and HF. Communities have been empowered to know their role. I know of Katova, we are likely to find a monthly report, NHC reports, give to supervising HC. Also Kanakanta. .
bb)	Other, specify: ----------
2	In your view, have ZISSP activities affected any changes in the following areas: *Coordination of key stakeholders; ongoing clinical mentoring, Supportive supervision, Providing human resources through seconded expert staff and support of retention scheme, Providing financial resources, Participation and provision of TA support in national, provincial and district MOH planning and budgeting activities, Implementation of grants program/capacity building of grantees in grants management and organizational development* Even here at management level, ZISSP has supported us to understand our roles as managers here. Especially in terms of data utilization. Because of these meetings, under the MS: planning, reviewing of action plan, may not be 100% but something that we can improve as an individual.
Section two: Capacity Building	
3	What ZISSP strategies or activities are you aware of that have helped to strengthen community participation in improving health? **[Prompt for SMAGs, NHCs, HCAC]** As a district, do you feel confident that you are more able to work with communities than before? Yes, especially for the sites where ZISSP has strengthened. Of course there are other partners already in community, but mostly where ZISSP has been, because of being constantly n touch with communities, maybe ZISSP will come in to sensitize the people. Can you give an example? When we were going for the measles campaign last year, there were some sites that ZISSP was supporting where previously centers were only achieving about 47% coverage, but after sensitizing community and mobilizing by ZISSP, they achieved the highest %age coverage. Before, even if you say govt can apportion monies to community, people in community didn't know what money was for, but now they have been empowered to address some problems facing in community, whenever they are demanding community funds, you find they are linking it to health improvements. We have been giving them the 10% and they understand the reason for it. If they don't have a mother shelter, or growth monitoring scales, this is what they ask for. In how many communities have you seen this change? Three in particular, *Beatrice please add the names.* Does ZISSP support one HF that is located way out? Namanongo? No they don't support that one. That health post just opened late last year, so some community

	members from there are participating in Chinunyu. So somehow the community is represented in the ZISSP work.
4.	Based on your experiences or observations, how have ZISSP community focused activities addressed gender issues (e.g. household decision making, gender imbalances among health workers or volunteers), if at all? Can you say ZISSP is making any difference in gender integration or inclusion of gender in their activities? Yes. Examples? They categorically request two officers to undergo training and please balance gender. Also asking that participants are equally balanced in terms of gender. That is very prominent in their program. When you are doing planning at district level, have you seen ZISSP coming in with any gender analysis tools to think through planning from a gender perspective? Has that happened? He saw a tool but didn't work with it. They emphasize gender balancing (but not gender analysis).
5	Based on your experience or observations, do you believe that quality of care at community level has improved? If so, what groups of community members have benefited most from ZISSP activities? Are there still groups that are yet to be reached? Volunteering is a very difficult strategy whereby one will spend time for nothing. In Katoba you will find that people really understand and appreciate services and demand and generate using their own resources, with other partner suppsort as well. Yes there is quality. (vague answer) People understand and they demand.
Section three: *Human Resources for Health:*	
6.	In what ways has ZISSP helped to attract and retain health workers in rural positions? Dr. is on retention scheme: "I haven't liased with my other colleagues who are on the scheme, but I've spoken to people who I know are wanting to go out, and they speak of this as a motivation. Don't know about those who are already in the outskirts, if they feel the same way.
7	In your opinion this context do you have an opinion about any benefits of the following specific capacity-building programs promoted by ZISSP: This is her 5th year on the scheme. She gets 2,100 kw per month, the categories depend on area you are in. She is in category B. Hasn't received payment since January, but reason was explained to us last week, there was a team that came from Community Development office under MOH accounts, they came to explain that with realignment of ministries money had been sent to MCD but they didn't have capacity to manage it, so money has been sent back to MOH. It's just this removing of staff from one ministry to another. There was a time, in 2011, when there were some problems, at that time it was a funding problem, partners who had been supporting the program were not forthcoming at that time. We went for a period of months without receiving. But got

	arrears. There are some HFs that get home improvement loans and vehicle loans, though not for this new contract (3 years), the first contract, everything was available, I got a vehicle loan myself, didn't' know about the home improvement loan until later, missed that one, for this new contract, same issue of funding had come in, so we were not encouraged to apply for loan not sure if would be money for that. A lot of applications already that haven't been approved or funded.
8	What are the most important issues related to attracting and retaining health workers in rural positions that need to be addressed in the next two years? Maybe if they can extend it to other health worker cadres, we know the MO is taking into consideration cadres that are highly educated, need to stay. But if looking at remotest part of our district, how do we motivate someone to stay there happily if she or he is given similar salary to one who enjoys electricity in their location. We mean nurses, here the scheme just covers tutors, doctors, DMOs, medical licentiates. Not nurses or clinical officers. Why? Not enough resources. Doesn't' seem to be the same policy in all provinces.
Section Four: Coordination and Integration	
9 a)	In what ways has coordination and synergy of HIV/AIDS, MNCH, Nutrition, FP, and Malaria services provided by stakeholders (MOH, USG, other donors, private sector health facilities, etc.) in ZISSP target districts been strengthened? In 2011 or so ZISSP supported us in bringing all partners here (to district office) so we could understand who is doing what. To us that was coordination, we could tell which partners were implementing what in different areas. For our offices here, because of these constant meetings maybe quarterly it helps us understand when we are reviewing our activities we are able to know who is doing what and what contributions are coming from this end. Down to lower levels, health centers also. Does ZISSP share its budget information with you for this district? ZISSP does share budget information, because there are 3 officers based at Lusaka PHO, if talking about clinical activities, must be a pull system, a demand system,we can send a budget to them with request, or they may say for this line we have this much money. For a particular period, they are able to break it down by quarter or by month or 6 months.
b)	Which of the above health services have been integrated in Health Facility at provincial level?
c)	Which of the above services have been integrated at Health Facility at district level? Has been mostly with MCH, not for malaria, we just take it as part of MCH, for FP, ZISSP hasn't been very active here. What about for nutrition?

	Maybe last year at hospital? What I know is that infant and young child feeding support is coming from UNICEF. (Beatrice comment: Chongwe because it's so close to Lusaka is actually flooded with a lot of partners; a lot of piloting is done here. This district is swamped with so many activities. So ZISSPmay not want to duplicate what other people are doing) At district level, when ZISSP is supporting you to do your planning, how are you planning? Are you thinking in terms of integrated services? It's integrated, our documents the action plan takes care of all activities or program that we do. We don't have a document to say this is just for malaria. But there are components for each kind of services within the document. The budget is broken into community funds, clinical funds lumped together, first level hospital, schedulable activities (mostly outreach).
d)	What are key challenges in integrating or coordinating health services across the 5 areas
10	In what way, if at all, has ZISPP facilitated coordinated planning at provincial, district, and/or HF level?
11	In what way, if at all, have multi-disciplinary clinical care teams strengthened coordination of services at provincial, district, and/or health facility level? We have team here at district and then one in Mubansah at hospital. In the new district. Why there? Actually it was plus for us, we just had one district, for us to have an extension there was a plus. And now, they have settled down in Rafunsa , they also need to form another team at the new DHO office, they are trying to strengthen the one at the hospital. The hospital is new, just 2 years there, certain offices or positions still being created. Under clinical care, the new DMO she is also clinical care officer for hospital, because position is not yet under establishment, to assist and organize ourselves. This hospital in Chongwe doesn't have a clinical mentoring team but there is an individual charged with this. In the district, about six people have been trained in clinical mentoring by ZISSP. Two under this hospital but one has left the district. Both of the respondents are members of the clinical care team. Can you provide a few examples of what you do as mentors? Haven't started this yet for Chongwe. Even HFs have not yet received clinical mentoring. But with other partners like PMTCT mentoring has been taking place every quarter. CIDRZ. ART clinical mentoring. Also with CIDRZ. What about QI? Are committees formed? Yes, there is one here, we combined these two together, but there are some people with QI who are not part of clinical team. Have you conducted any QI visits? Not yet, but we have done one training at hospital, is this a cascade training? Yes, we did it as a district. (this is new). The complaint has been we have a performance assessment tool, there is a component whether they are asking about the existence of a QI team, what activities have been done, for some years

	this has been recorded as committee existing but not trained, so we decided to start with this training for the committee members so they know which activities to follow up and improve. On the other side, Rafunsa, there they have a committee but we are not privy as to what they are doing, they are not yet trained. They are not following the QI team guidelines.
12 a) b) c)	What could ZISSP do in the remaining project period to further strengthen integration, coordination and/or synergies among other health services: At national level: At provincial level: At district level:
Section Five: Country Ownership	
13.	What is the perception of MOH and NMCC regarding ZISSP seconded staff's role in building capacity of Government of the Republic of Zambia (GRZ) counterparts to plan, design, implement, manage, monitor and evaluate health programs at the national, provincial and district levels?
14.	How would you assess the ZISSP seconded staff's role in building your colleagues' capacities to plan, design, implement, manage, monitor and evaluate health programs?
15.	How do you rate the specialists in these specified areas?
16	What are the most important issues for which the respective specialists are responsible that need to be addressed in the next two years? j) Clinical Care Specialist; Nothing to change or add, what may be requested is that if we can be able to access support in a timely way; their system is maybe we are in second quarter, but it depends if funds are available, or if that seconded person is not otherwise committed, you have to push your activity, talking about time delay. So if support is requested, there is normally some delay. Money comes, but not a specific amount dedicated to this distric.t we identify need, make a budget and request, wait to see if they can support and when.

k) Management Specialist;

When we have district integrated meetings, as well as planning, performance assessment, she is always on site, don't need to change anything there. Taking care of all facilities at district level. Did an EDU training here. Has it made a difference? He didn't' participate but because of these constant meetings and data review, we are able to challenge each other. When someone is presenting, we don't just take it at face value, we are now probing. EDU had some impact in better understanding of data management and review.

We can request, if resources are available, let there be regular meetings for review of activities on a 6 month basis, that is where we have got inadequate support, are we moving on the right track, the district aggregated meeting is you bring all the health center in charges let them come meet in one central place, let them be able we have got a template that we use a format we use, pick the pertinent indicators, they must feed into national strategic plan, attempting to address the MDGs. See how you are performing, what is your contribution? If that is done every6 months, want ZISSP support for these meetings. Because the performance assessment is not just focused on Chongwe, but these meetings can focus on Chongwe.

You go through your data and look at specific HCs that are contributing, if you bring them together there can be some lessons learned, and you can make adjustments for interventions. Used to work very well when we had good support from GRZ, now the number of HFs is increasing, so we need to have these meetings. RBF is not here to provide this kind of support.

We do have partners here, the only different with ZISSP is that they take a holistic approach. CIDRZ BOMA approach will not entertain anything to do outside primary health care, clinical care. Not the broader management aspects. Clinical care standards.

Mr. Chonge has discussed this request with the MS person, last meeting was supported by ZISSP, last November. Worked very well. This year, these review meetings are very much tied to planning office, we wanted to request again.

We don't' fully give it to ZISSP to support, we also have to meet half way, so government is making a contribution. It's a partnership. We can't do it alone, only half a day, cost is high.

l) Community Health Coordinator Specialist;

Under community, better to do it way it's done under MS, because clinical takes care of whole two districts. Communities don't know why ZISSP only picked about 9 HF to support, would love to be extended to HFs so that communities in all HFs are reached, empowered with information, so there is uniformity. We are talking of 38 HFs, forget about hospitals which have different structures of community participation. They have got HCACs, if we only pick about 10, the other 28 are not attended to. Impact is not likely to be all that significant, # empowered is smaller than those that are left out. What the strategy to cover all the areas. Let the same information be extended to other sites.

It's a very good approach, actually have seen how made people participate and linked

	people to HFs, Information is flowing better, so let the same information be extended to other sites. Can be a continuous process being done at every HF then bring those together, some say we are supported by ZISSP, others want to know how were you picked to be supported by ZISSP Better if support is uniform. Namanongo, one area which needs to be strengthened. Don't even know whether NHC knows their roles.
Section Six: Gender Integration	
17.	To what extent have women been empowered to take action in support of health behaviors and interventions in ZISSP target districts? [*Participation as volunteers, Leadership roles in community groups, participation in community health planning, participation in distance radio learning program*]

When was last MOH grant received? Last received in March for January and February.

IMCI – any training there? Yes. Last one was 2011.

On Wednesday, will plan to visit Katova in the morning, see HCAC and HF provider. Go to Chinyunyu in the afternoon, find chws there and beneficiaries. Mr. Chongo will go with us, meet at DHO at 8 am.

Marie Stopes has come in, and also Society for Family Health. Are they partnering with ZISSP? No.

Interview with Mrs. Beauty Pallu, Malaria Focal Person, Chongwe District, Enumerator Deborah McSmith

1. Please describe the ways in which ZISSP has supported malaria prevention and treatment in this district.

For the IRS, ZISSP has supported training of spray operators. IRS started in Chongwe in 2005, she came in 2008, since 2008 working with USAID partners. How many spray operators have been trained since 2010? Maybe 50 every year. About 150. Both men and women. This is at the district's discretion, rule is at least half men and women, 50 50. This is a government policy.

Does ZISSP support spray monitoring? Yes, there is monitoring from NMCC, ZISSP and provincial official, but they all do separately.

There is a form for spray operators to capture information, they capture the number of ITNs they find in a house. Firs they will ask how many nets are in the house and do a visual check to see how many beds have nets. This is part of their training.

ZISSP also supports the implementation of the IRS. They pay the supervisors, they supply the Personal Protective Equipment, they train the supervisors, they support the pre-spraying

meetings, where maybe different districts come together and the supervisors are trained how to go and train the spray operators and then supervise them.

They also come together after the spraying for post spraying meetings. There are a lot of partners at the meetings.

Once a year the spraying happens, normally we are told it should be done twice but we just targeted the peak periods when malaria is really big, so once a year.

She is not aware of whether ZISSP supports health facilities in terms of FANC or Malaria in Pregnancy, "this may not directly concern me." Doesn't know about FANC or IPTp promotion; she is aware that in HF there is IPTp where pregnant women are given fancida, doesn't know if ZISSP does that.

Looking at the malaria trends table:

Question 1. We have been looking at this question as a district. We saw a change from 2010. At one time like 2008 or 2009, when NMCC would do a survey, could go around and not find a single positive case in the township. When cases started going up it made us worried; if someone tested positive for malaria, they were followed up in houses to find out where they had been. In the eastern part of Chongwe, in Rafunsa district, have a lot of malaria, would find people with malaria had gone to visit someone in the east. Apart from that, for these high incidence places, I tend to think since DDT was stopped, we began to see more cases here. This is one of the reasons for increase. Now we are using pythetroids like icon andvetron. Sometimes kotrine.

Question 2. Meaning is unclear.

3. The community radio station is not yet operational but yes we are doing BCC messages. One problem here was that people would get ITNs but use them for other purposes. With help of malaria agents in communities, we are giving health education. One particular area Kasenga, that was a problem, we have reports that has stopped. Malaria agents go door to door and also do group education. When we have IRS we have a launch. We go out in the community like we have been doing since malaria commemoration day, we are doing this now with World Vision, couldn't do on the day, no funds, so going itno communities mobilizing drama groups, they perform, people listen. The drama groups make a difference. But the difference is difficult to measure. I believe that when people learn, they know something, they remember what is right and wrong. What we've told headman is if they catch someone using an ITN for fishing they should fine them. They are happy to do that.

4. We target a certain percentage of houses, our desire is when we go into community we want to spray all households, but sometimes owner not there, sprayers cannot go in. Maybe the sprayers will be in the community for some time, we go back and try again but not always possible. A najor problem is when we go to Rafunsa, many of the houses are on mountains, people stay far away from each other, becomes very difficult to reach them. IRS targets clustered houses, that are near each other. When houses are too distant becomes spray operators to cover km or two, just to reach one house. Rafunsa is mountainous. Terrain is the biggest challenge for universal coverage.

Spraying in this area requires a strong vehicle. How do spray operators move around? We hire a truck and go to particular area and they move out from there, day by day until locality

finished. She has never heard of any spray operator getting malaria while working. We don't sleep there, just do for the day.

She is involved with IRS but not with IPTp except maybe just to take sure that the fancida is available, that pharmacy has it. How are drugs delivered? Pharmacist orders from medical stores, they deliver it here, when don't have it. District has had stock outs just periodically. Don't know why

ZISSP helped to construct the evaporation tanks where we do the washing of the spray pumps. Some environmental monitoring happens. ZEMA does it. Previously was done by the ECZ. ZISSP and ZEMA work together for this. Also helping in provision of insecticides. Purchase them and bring them here. Or to medical stores.

Who is the main ZISSP person you work with? Someone in Lusaka. Mr. Makusa mostly . Another one. Mr. Chirwa. CDC is also here but she doesn't work with them.

When will spraying happen next? Normally by July should start training of spray operators, if everything goes as planned. This last season started very late, financial problems, insecticide supply problems.

Consultation with the Acting Clinical Care Specialist for Nyimba District 15th May, 2013

ZISSP supported training in District

1. QI training was done in February and April, 2013. A QI committee was formed. Members have been identified and written to. But no meeting has been held yet. Reason was that Dr Mapulanga the ZISSP Clinic Care Specialist for the province was busy. The inaugural QI meeting has been scheduled for the end of this quarter.

2. IMCI training done last year and every facility has at least one staff trained

3. Nutrition (Infant and young child feeding). Participants from three facilities were unable to attend because the notice for training was short. They could not arrange for travel on time. The staff were trained in managing severely malnourished.

In the district, severely malnourished children are transferred from facilities to the district hospital for supplementary feeding.

Currently only two facilities do community work in improving feeding of children. These are Mutilizi and Chipembe.

4. Longterm family planning: Training was done. However, not all facilities have long-term family planning methods. Only the hospital and the hospital affiliated health centre have the methods. In other facilities the long-term methods are administered by hospital outreach. Facilities make bookings and providers from the hospital then travel to insert the methods at the facilities where bookings have been made. Supply

for Jaddelle is constant and there have been no shortages. The long-term methods have been well accepted and most women that want contraceptives prefer them.

5. EmNoc: ZISSP trained health care providers (nurses and clinical officers) in all facilities except in two that had only classified daily employees. The two left out were Mwape and Chinsibwe. These two now have male nurses. There are three full EmNoc sites - Chipembe, Hofmeyer and Mukopeka. The full sites also have complete EmNoc kits. But the rest of the health facilities do not have a complete kit.

Maternal Death Reviews

This is being done. Some reviews have been done. There is a district maternal death review committee and a hospital maternal death review committee. After review by the committee, recommendations are sent to the province. Reports for the reviews were promised to be sent via e-mail.

Mentorship

ZISSP is assisting in this. In March 2013, there was mentorship in TB and STI and just clinical cases and also under pharmacy. Capacity for mentorship is also there at the hospital. The hospital has mentors in different areas such as in PMTCT and STIs.

BCC in General

ZISSP has done a lot in Safe Motherhood with the SMAS. All chiefs are part of SMAGS. They have come up with penalties but they don't seem to work as expected. He wondered whether the reported penalties for home deliveries were being implemented because he had never seen a goat being brought to the health facility. So where are these penalties paid? There is a problem with posters. Most facilities were being painted and posters were pulled down. There is need to put them up again. The District Office was instructed to come up with a budget to present to present to the province so that there are posters in all the facilities during the safe motherhood week in the week of 20 to 26 May, 2013.
Despite the BCC, coverage in IPT3 was still low because the antenatal bookings were low.

ZISSP support towards Staffing

There are 6 facilities where personnel should be on the Zambia National Health Worker Retention Scheme (ZNHWRS). But now only two personnel are on it. And payments are not consistent.

Other ZISSP Clinical Care Support

- ZISSP supported a clinical symposium at one time. Reviewed clinical cases they have in district. This will be on going if promise holds so that it can be held in zones and other facilities.
- ZISSP strengthened the community structures in some sites. Model sites are just something in plan now.
- Recently ZISSP came to assist the district personnel how to plan. ZISSP sent a team of a Planner, an Information Officer and an Accountant. These took them through took them through the process of planning. Shawn how to start planning SWOT analysis, logical framework e.t.c.

Clinical Mentoring Conversation with Dr. Bupe and QI as well, Gwembe DHO

1. Involvement with ZISSP in terms of clinical mentoring?

First encounter was with clinical mentorship training, one of 5 mentors trained in first group in 20111.

We were trained and taught about clinical mentorship, after training it was expected of us to roll out program to district which we did some months later, have been funded by ZISSP to conduct CM, have had some supervisory visits from Dr. Nancy Zongwe.

Because we were only five mentors in beginning it was fine when tried to mentor per facility, but need was greater than # of people trained, so at some point we had to orient people not yet trained to help us with process, so we engaged other clinical people to help us when areas we needed to cover more than we could do, sometime we use people we've oriented to be mentors.

I've seen that it's been quite helpful in that only opportunity we had to mentor or train or provide technical support through technical support visits that occur bi annually after we've conducted performance assessments for district; if only doing things twice a year imagine how many things we are failing to address, but clinical mentorship gives us opportunity address issues quickly, even with outbreaks we use clinical mentorship as way to train people on management, has been a nice intervention it address issues in timely fashion.

How often do you do these CM visits? funds from ZISSP comes very two or three months, but because we've seen how important it is we don't always wait for ZISSP funds to come, instead take advantage of others program, eg for results based financing assessment, use those visits to go back and mentor people on those topics, or take advantage of mobile ART clinic s it goes to facilities, a mentorship team jump on and takes that opportunity to go and mentor.

We don't always wait for funds. It works well integration wise, but in terms of motivating staff who actually do the work, we are left wanting, now it just becomes a service, with ZISSP there is an incentive, a lunch allowance, a bit of a perk for the staff. These perks are important, just to g tot one center is very taxing and it's far. By time you get there, already approaching lunch time, by time you start to do your work, at least just a lunch allowance is a good motivator.

Who is supporting the results based financing program? World Bank through Ministry of Health, eventually they expect to hand it over.

How did you orient more staff? We used our manual and tools from the training, called a team together, did a mini training. Cascaded the learning from their training.

People were willing to do this, what we found out is sometimes you can't know everything that's going on in your area, they were aware of problems in various areas that they wanted to teach on, knew where they wanted to start. A lot of enthusiasm from new team members.

We understand you have a multi-disciplinary team, which cadres are involve? Medical doctor, myself, then clinical care officer who is a CO, 3 nurses who comprise two midwives and one registered, nurse. They do most of the MCH activities; whereas the CO and myself would approach more clinical subjects.

Beatrice met a gentleman yesterday who works in the lab, he talked about being a member of the mentorship team, he is one of those we had to orient. What happened is we realized that clinical issues cannot just be clinical on their own, they rely on other departments such as lab service or vaccine management, so need to orient people in these areas as well. people were not preparing TB sputum smears properly, so we realized we need to engage his services to go out and mentor this. The people on the team go with the need. just orient them and bring them along.

The 3 page tool is the reporting tools. One is the actual mentoring assessment tool. Every time we mentor we make 2 copies of the report, one to send back to ZISSP and one that remains here.

Nancy reads the repot and may give feedback. She mentors the clinical mentoring team. Depending on report we send, if she feels there are areas we should have focused on, she will tell us what areas to focus on these area only, she is strongly guiding the clinical mentoring that we do.

What happens when she goes away at end of 2014? We are pretty independent now, her guidance comes in when at national or provincial level she discovered areas of weakness or need then she gives direction. I still feel we do need her in sense for when it's time for reporting or identifying how to improve on something. Still something we could sustain on our own. Her guidance has been really good; there are some times in your own district not knowing in the neighbouring district is facing certain problems you don't yet know about.

How does clinical mentoring relate to supportive supervision?

The supportive supervision is more fault finding, identifying areas of weakness, and when you go back you are going back to be sure mistakes are corrected. Support supervision is more of an activity not so much a process. This has been covered. Whereas mentorship is more of a process because you have an actual relationship with the person who is involved, you look at reasons for non-performance.

TSS wouldn't have that personal involvement.

Difference is one is an activity, the other is a process. Not every mentorship visit is successful. I may go to address this topic, person may be not entirely comfortable at end of visit, it's an ongoing process over time.

How often is TSS supposed to happen? Supposed to be quarterly, but follows performance assessment which happen bin annual.

How does clinical mentoring relate to the QI activity ZISSP has supported?

Has just started, only rolling it out now. Both are working toward same thing, after we conduct a QI assessment, then it will help us identify areas of mentorship, that's where those two programs coincide.

Have been getting funds from Z for QI, having meetings, forming committees, have formed a committee there is one here and one at the hospital. On the district committee she is chair person, we have a traditional healer and a church representative. Chose the most promising church in Gwembe. Then the traditional healers, why because we found these are basically our competition when comes to health care, could work together, if could educate

them on certain things, let them identify where there are areas out of their comfort zone, let them refer. That is our approach.

In the hospital QI committee, we have a village headwoman from nearby village. There are women leaders.

How often are committees meeting? There is enthusiasm for this work, especially from the community has really been interesting for them, didn't' realize they had a role to play in the formal health system, getting to know about how we operate, why we operate the way we do.

What support to make sure this gets rooted and can be sustained.

Where we would really need help is upon doing the first quality assessment, should we identify areas and embark on a project to deal with that, it would be nice if ZISSP could fund those specific projects. Eg if having a lot of infant deaths from certain HF, we could go to investigate and if in doubt why, would be nice if ZISSP could support that effort.

What would support look like? Transport, allowances for staff member to travel, good if they could fund some research as well, if some people discover a research topic would be good if Z could allocate funds for that. Helping the facility as such, the result based financing does that. Would be replicating

What RBF does is it gives you funding based on your performance. If a HF going well, they make more money for themselves, they are supposed to use money not just to empower workers but to give back to HF. So that area is covered. So long as the facility is performing well.

So if you do more of the QI, then you are assured that HF are able to get more money through the RBF. So the programs work well together. This is one thing they talked about in Munyumbwe. As we provide the quality care, we have a plus under the RBS. They have seen the QI process as something that is handy and timely and have seen the synergy between the two programs.

One is improving quality of service, and the other is acknowledging and funding the performance.

Those two really linked well.

What is time frame for WB RFB support? No idea. Same intention that the MOH eventually take it up.

How feasible is this expectation? Depending in success of program, would be feasible. The challenge of different programs is being able to sustain it. If Gov were assured funding to sustain it, no problem. Where we have a problem, is where Gov takes on responsibilities they cannot continuously fund. What happens is the districts are left wanting; you have people trained, knowledge not being put to the test.

We have heard about people being trained by ZISSP and then not having commodities

Our big facilities are Munyumbwe and Chaboboma. LTFP commodities are expected to be there. They are the mini hospitals. If we happen to train someone from outside these HF opportunities to practice are minimal. What we have in most HF are injectables and pills,

but not implants. At the smaller HF ideally, we are supposed to have a midwife and a clinical person or two nurses, but what happen is maybe we don't send midwives and a general nurse is not familiar with minor procedures like putting in the implants.

In terms of equipment, is CIDRZ supposed to support that or do you have a different partner?

So far equipment wise it's been ADRA with the Collin Glasgow Foundation. Have been really funding a lot of equipment in the district, medical equipment, not EmONC, some of it yes, depending on what we request. The DHO sends a list of what is needed and they fund the list.

Has ZISSP funded any equipment. Not sure. Ask the MCH coordinator.

Has been highly useful sustainability comes down to money, transport, and retaining personnel who have been trained.

With the few visits you've done, have you seen any key changes that have resulted?

Right now we've only managed to assess the hospital only this coming week that well start coming to HF. At hospitals they have been able to start sorting and setting things, we had ignored the part of client's rights, we are actually looking at that, trying to see if we translate the client rights and have them posted at the hospital. The levels of illiteracy here are high; people don't know their right or have an idea that they are entitle d to certain things. Our plan is to use community members to educate people about their rights and have them print out (does RDL program include client rights?)

Interesting to learn from Munyumbwe saying some of key changes they have seen, they had forgotten about just doing simple things like vital signs, using BP machine, weren't bothering. Now after training they needed those basic tools, using the extra money from RBF they have been able to buy these things.

Lab person said samples coming in for TB smear, great improvement.

Opens up eyes to a lot of things that you thought were trivial but are actually very important. As soon as we can properly roll this out to all the HF, you'll have a quality standard everywhere, the same at hospitals and at RHCs. With time we are saying that it's becoming a standard, everyone suing digital BP machines, "we are beginning to standardize quality."

Do you think you will eventually see a link between improved quality standards and health worker morale? Depends on HW attitude, can't do much about HW attitude if negative. Before a lot of our workers of putting on the uniform, big deal, didn't realize it's infection prevention, way of bringing pride to your profession, people didn't understand until we sat and said "The same uniform you've been dealing with patient, rush home, what germs are you taking there? "

For people like me who didn't study in Zambia, I studied in Russia, a culture shock where we go to hospital expected to change our clothes. Those things remain in lockers. When came here, was astonished that people didn't change clothes. How do you start to make a change? Only now when you get to be involved in such program, trouble with such program these new things, have help us realize about standards, are only implemented at district level. Would be nice if also implemented at central level.

Ask if and how QI is directed at central level. Hasn't heard about a central level clinical mentoring team. ¾ of us first pass through the central level hospitals before brought to rural areas, obviously if you learn wrong things from central level, that's what you bring down to HF level.

Anything else in terms of what Z has been doing in this district? Aware of community aspect, but don't know exactly what they've been doing. They have been quite active and involved at community level, which is a good thing. When you do most of our assessments, you find that ¾ of the reasons behind non-performance or good performance is based on the community, their involvement or lack of involvement.

Per Beatrice, HF acknowledges there is great change due to community involvement linkage is something they never enjoyed before. There were saying the HC now even do interventions that reach the HF, they mobilize the community to come and clean up the HF without paying anyone. Because of their hard work they even managed to buy Chitenge materials for each member of the NHC and give to them in appreciation for what they are doing. Get to see if HW happy, community happy, a facility really thrives.

I remember when I first came, everything about Gwembe was negative, for performance in bottom two, literally hanging your head, but now you can see the difference people will say maybe Gwembe can tell us what they've done to improve this, we've seen this has happened in Gwembe, teach your friends, now getting recognition. Nice when even from top people are noticing that Gwembe has improved. No longer at the bottom. Encouraging us to teach other districts, provide technical support to other districts. That's real evidence of change.

Only ZISSP focused on QI and clinical mentoring, though I think the RBF program has seen the essence of mentorship, so they might be looking into areas of mentorship for future as well. They realized at last meeting they hadn't thought about it, but are looking at it now. They also look into QI in other places, but not here. For them it's just about having perfomance standards, with QI it's more investigative what could you do, more problem solving.

It's nice when you do have partners in the district, but where you have a problem is where too many partners are doing too many program, they all have their own tools, all require reports. Very taxing. I remember when it came to HIV , found some partners were replicating each other's work, how is it that data from this group is different from data this group collects? Could we come up with tool. Reduces reporting workload for district.

DHO does call for quarterly partner meetings where we present data challenges, achievement, statistics. Originally all partners. Every week the DHO has a morning briefing, partner representatives are supposed to attend, give a weekly submission, hasn't been the trend. But do attend the quarterly meetings.

Performance assessment; how is it conducted?

Actually almost the same way we do the mentorship; we have 3 multi-disciplinary teams that go out to different HF – we have 12 HF. They go out and assess the HF using a tool made at national level; are you aware of ZISSP's involvement in development of that tool? No not aware.

Have seen need to revise the tools, doesn't actually grasp the information that is need. very complicated tool, someone who hasn't been oriented won't understand the tool. It too me ages to understand it. Have been talking about revising the tool.

How long does an assessment take? Could be done in one to two weeks, depends on size of district. For Gwembe week and a half. But cold take a month where have say 53 HF.

What do you do with the findings? Tell us which areas to provide technical support to. Produce report. Province comes in and does a performance assessment on the district and then compare the two results. They come up with recommendation for areas to improve. This is essentially a TSS plan. Provide foundation for province on which areas they should provide TSS for.

Probably at some point it also provides some Qi issues; may identify some also a way of identifying certain indicators that haven't been met.

Working with the 5 national indicators; in the QI committees this is what we decided to work on. Decided to do project based on those indicators. Will pick up one indicator at a time, able to know where we are doing well.

Only ones who may have challenges in how pieces fit together may be new staff, otherwise the management team understands how it all fits.

Asked about what pieces of plans fall out when funds not enough, this is a common occurrence across districts. Sometimes we talk with other supervisors form other districts, compare notes on who much they got. Common problems,

Munyumbwe indicated have been able to fund a NHC plan, building pit latrine or toilet for health post. Were able to fund that. Through RBF money. This money has helped to address some of the shortages. Sometimes we get a partner who will also fill gaps. They talked about sensitization on BF, had that in their plan, were able to fund and took place.

Easier for Mumyungwe to get funded, some partners have bases in MUM, like World Vision, so HF can ask WV for things and they will support. For those farther away, harder to get that support.

How does management team keep its motivation high even with funding constraints?

The key thing is when all these programs come bout, when mentorship, TSS, we try to involve everyone so everyone benefits one way or another. If you are leaving out certain people, same people going over and over, those not involved stop performing key thing is to involve everyone, rotate for trainings, try to involve new people.

Have seen Maureen lately, have seen a lot of Eridge and Dr. Zongwe. We get to see more of Nancy and Eridge because their jobs are more decentralized, have to actually to go into HF. Because Maureen deals more with management and governance, here work is more here, this office. Eridge and Nancy are more often in the facility.

How likely is it that the Z seconded staff contributions can be taken up by PHO when they leave?

If positions can be taken up MOH, their tasks can be integrated in that person's SOW. Sometimes these programs are too involved for one person, maybe have one or two other

people they could delegate with a clinical care program. Not doing away with it, forming a unit in charge of all that. The way they've divided 3 ways, maybe have a unit to do all. if you say you're going to hand it over to one person, a lot of gaps, too much work for one person.

Started the program for clinical mentoring even before Z sent funds; has sent her a report that she is still editing, did give some feedback, copy of minutes. Showed us the folder.

QI meeting minutes – have reviewed the 5 quality indicators, decided to start with malaria. Made a check list to decide how to proceed.

(This team may end up providing best practices for other committees.)

Could think of making Gwembe a model QI facility for other districts to learn from.

Has heard about ZISSP having model sites in various districts? Hasn't heard of it at all in Gwembe.

Not yet happening here.

Made checklist on different areas, request a photocopy of checklist, maybe include as annex in report?

Didn't have guidance on what to look for, so developed the checklist. Nancy said showed good initiative.

Kalomo: Conversation with Esmart, SMGL District Coordinator (While Traveling In Vehicle)

Esmart has 11 health centers where she monitors SMAGs.

Also 28 HCs and 2 hospitals with EmONC services.

She does supportive supervision with the DMO. They look at: cleanliness for infection prevention, record keeping, progress with use of partographs (was not previously used before ZISSP started, except at the 2 hospital, new to HCs), notes other gaps and conducts problem solving together with HC staff. While she's there she may work with women in labor, mentor the staff.

Re **QI:** She is doing direct capacity building, helps midwives conduct patient exams, review patient files to record properly, HIV issues, the whole package. Tries to visit HF each month but can't always do all. At 4 HF she does these visits combined with meeting with SMAGs.

At one HF saw an EmONC cubicle provided by ZISSP. She said this has been in collaboration with DFID, through CHAZ? BU ZCARHD brought skills. MCHIP trained staff in neonatal resuscitation. BU also supplied a small untrasound machine. (sounds like a good example of coordination and harmonization; can we find more details about this in a report?)

When she went to what? conference in Lusaka, and also a planning meeting in Lusaka in January, she took that budget to a CDC meeting, it was cut some, then took it to conference.

Started strong, then reduced the budget, hard to sustain. Who reduced the budget?

Copperbelt Province PMO Office, Dr. Chandwa Ng'amse PMO, 042213
Paul, Jean, Edmond, Amon from MTE Team

Dr. Ng'amse welcomed the team to Copperbelt PMO. Overview of province: one of the most heavily populated provinces in the country. Lot of in-migration looking for jobs that causes squatters on the outskirts of Ndola. High HIV+ population, and high malnutrition due to the nature of the province. ZISSP has worked very closely with them "for years" (seems they were also part of HSSP. "We have benefitted from Human Resources, money, tremendous support. Many (over 8) PMO staff plus 2 ZISSP staff have been through ZMLA. They have also received technical support in HRH, Financial Accounting and Information training.

A lot of the updates in the Performance Assessment (PA) tools upgrades and he has seen improvements over time. Today they were looking at how we used PA Reports and compared with the way we work. Now we have a PHO PA tool, which we never had before.

ZMLA is very good. But for himself, he could use a more targeted training that would help him assess his own areas of weakness with more one on one mentoring rather than a group. He said (and several nodded) that supportive supervision is something more suited for OJT and one on one mentoring. Other parts of the course he didn't need (like how to write checks). He doesn't recall if they did an individual needs assessment prior to the start of the ZMLA course. He feels that everyone should be certified that they have a certain level of understanding of the contents of the course. They (at the PMO) participated with BRITE when they set up the course. For "after" the "basic" course, he recommends short courses targeting specific individual things the students wants to improve and not have everyone at all levels go through the same course.

SMAGs: "I have my own opinion, but the others may think differently". But they are valuable and will need sustained support. CHWs have had high dropout because they spend weeks of their time and get no payment. Both CHWs and SMAGS are valuable. MOH should consider providing support (i.e. paying them) because they are valuable.

The MTE discussed the scheduled plan to visit districts, HF and communities. No CHAs in communities yet, but they have students in the current cohort. In one district, Save the Children is working on newborn treatment as part of the Saving Newborn Lives Initiative. All community structures are coordinated at the health center.

The MTE set up appointments for individual interviews with PMO and ZISSP staff for the following day.

DCMO Gwembe Informal Inteview May 2nd – Dr. Oscar Mwiinde

Deborah and Beatrice – had already completed the formal interview with the former acting DMO, this new DMO has been in the position only 3 months, so we engaged him in a briefer informal interview.

He previously worked at the adjacent district hospital, then was away at school for 2 years.

1. **What have you heard in terms of what ZISSP has been doing in the district?**

He knows that the former acting director had an opportunity to do some CB with ZISSP by participating in the Financial Management for non Financial Managers training course. Also he attended the Epidemiology for Data Users course. Also Dr. Bepu and 2 others from the hospital were trained in clinical mentoring and Quality Improvement.
Coming to the community, ZISSP has been active to assist us to conduct national events: child health week, measles campaign, also radio announcements on the community radio station, also drama groups. Also ZISSP has trained more than 20 NHC members, who have oriented more than 200 other members.

The district has been planning to have an integrated district meeting together with APAS training; he communicated with Maureen (MS) regarding some assistance from ZISSP for this, they made the request in February. Maureen has said it's being looked at in Lusaka; they need funding support to have the meeting.

2. **When did you receive the last district grant from MOH?**

At the beginning of April; that was for February. We have received grants twice this year, for January and February.

3. **Have you heard about the ZISSP grant support program for CBOs and FBOs?**

No, he has not heard about the ZISSP grant program.

4. **What have you heard about QI?**

A few staff have been trained by ZISSP both at district and at hospital. The purpose is to ensure that we maintain high quality in the care of our patients. The QI committee has had a couple of meetings since February; the last one was at the beginning of this week.

5. **Are you aware of any other QI programs that have operated in the district at any time?**

The only similar exercise I'm aware of is Results Based Financing (RBF) through World Bank. There is an integration between the two programs. As for the past, I don't remember any partner doing this.

6. **Are you aware of any ZISSP supported trainings for HWs in the district?**

Yes, there have been trainings for BCC, QI, clinical mentorship, EDU, FM for non FMs. When prompted, also remembered EmONC but "not since I've been back". Also remembers IMCI. Emphasizes that ZISSP needs to train more staff in IMCI; there has been a lot of staff attrition. Dr. Bupe has been trained to train others.

We will always need partners to come back and give us training support. We face big logistic challenges; funding is not sufficient to cater for the things we want to do.

7. **What about a strategy to focus training on districts using hospitals as training sites rather than send HW to provincial level for training?**

It's a good idea in theory but the challenge is space. This is a small hospital. But good idea to host training in the district where people understand the realities of the HF in the district. There are training site possibilities: World Vision has conference facilities in Munyumbwe, also the Council guesthouse there, or there is also a recommended guesthouse in Sekesi.

8. **In the HFs you have visited, have you noticed any changes since ZISSP has been working here?**

Yes, mainly the involvement of communities in health activities. "You find groups of people at HFs discussing health issues; having IEC materials, there is high enthusiasm among the chws. What surprised me was how active people were; there is now more activity, far more enthusiasm."

9. **How many CHAs are in your district?**

6 to 8. The supervision problem is lack of fuel and vehicle maintenance given the rough terrain.

10. **Do you have any recommendation for ZISSP in terms of what they could most usefully do in the remaining project period?**

- How possible is to get Gwembe in the grant support program?
- There are SMAGs in other districts; we'd be happy to have them in Gwembe. Here we have low ANC uptake; low institutional deliveries, and resistance to delivery by male health staff.
- Don't know how involved ZISSP is in the retention scheme; is there a way to assist gov so that the payments come on time; currently they are erratic. Also the amount has been stagnant for quite awhile.
- ZISSP assists 3 HFs and communities are stronger there, but would be more beneficial to spread this support to other parts of the district too. We send radio messages and the word goes out so nearly all HFs are aware of a program even if they aren't a focal HF for ZISSP.
- He would be glad to personally be able to attend the EDU, FM, QI, and CM trainings. He has received 2nd hand learning from colleagues who have completed these trainings.
- He requests ZISSP assistance for the district integrated meeting and the APAS training. Had planned this for mid-March, submitted a request in Feb but money not there, deferred to mid-April, still no response from ZISSP; now will schedule when money is there to make it possible.

Consultation with the Previous District Planner for Nyimba District
15th May, 2013

Name: Mazala Mazala

Mr. Mazala Mazala was initially trained to be an Environmental Health Technician. Thereafter he studied a Bachelor of Arts in Development Studies. He then applied to be the district planner. The district office recommended to the provincial office which in turn recommended to the Ministry Headquarters which then recommended to the Public Service management Division (PSMD). However, while waiting to be appointed by the PSMD, the PSMD filled the position of the Planner in Nyimba with another person. Mr Masala feels very disappointed but since the new Planner was not conversant with ZISSP interventions he accepted to answer questions about the ZISSP interventions in the district

ZISSP Support to Planning

1. Zambia Management and Leadership Academy (ZMLA). Many staff in the district have completed the ZMLA. The first module was in February/ March last year. Couldn't remember when the second one was. The third one was in December and the last one in April, 2013. The staff that attended the ZMLA were drawn from various departments in the district. They are:
   I. Mr Tembo
   II. Mr Kasaro
   III. Dr Nyambe
   IV. Dr Chama
   V. Mr Chuzu
   VI. Memory Sakala
   VII. Brian Bulaya
   VIII. Lombe Kolokoni
   IX. Haswell Kapomba
   X. Timothy Kanyama
   XI. Mrs Grace Tembo
   XII. Daniel Sikazwe (Did not complete all the modules)
   XIII. Fred Kasashi

The new planner is not yet trained in ZMLA

- Not all Neighbourhood communities have been trained. Last year, 24 representatives (one from community and one from the facility in the community catchment area were invited for training. But it appears that it's better to interact with the whole community because representatives never share what they have learnt with the community. The training covered elements of planning and how to draw up community action plans

- Community involvement in planning is weak in Nyimba. In the recent past, the communities have not contributed to the district action plan. Currently old community plans are simply repeated in the district action plans. However, effort will be made this year to have the communities participate.

- Gender integration: This is not structured by way of strategy or written guidelines and monitoring benchmarks. He felt that this area was weakly attended to.

Eastern Province Provincial Office – Meeting on Malaria In-Door Residual Spraying, 13th May, 2013

Present

1. Mr Greyford Kachikoti Banda Provincial Chief Environmental Officer
2. Abgela Chitamfya ZISSP Seconded Management Specialist
3. Dr Mapulanga ZISSP Seconded Provincial Clinical Care Specialist
4. Deborah McSmith ZISSP Evaluation Team Member
5. Beatrice Chokotola ZISSP Evaluation Team Member
6. Kumbutso Dzekedzeke ZISSP Evaluation Team Member

Mr Kachikoti as the Provincial Environmental Officer oversees the In- Door Residual Spraying (IRS) programme in all the districts in the province. IRS is supported by ZISSP in all the districts in the province. Organisations / or Partners supporting the IRS programme in the province were 4 namely;

1. ZISSO,
2. African IRS
3. Zambia Nation Malaria Control Centre
4. The Ministry of Health

ZISSP support to In-Door Residual Spraying

ZISSP supports the IRS in the province in its entirety

- Trained Trainers of Trainers (TOT) of IRS
- By cascade from the (ToT), they ended up training the Spraying Operators in all the districts in the province including those for Chama district which has been moved to Muchinga province
- ZISSP pays the Spraying Operators
- ZISSP purchases the chemicals for spraying
- ZISSP provides money to hire transport to transport the chemicals
- ZISSP provides the spraying equipment
- ZISSP purchases the bread and milk and the Spraying Operators.
- ZISSP supported the geo coding of the areas to spray in 2010

Selection and Training of Spraying Operators

These are trained every year. Recruitment is via advertisements. Effort is made to recruit an equal number of females and males but that is not possible most of the time. More males are invariably recruited. Priority in recruitment is given to those that participated in the recent past. Those that have worked in at least three years are not recruited because they are likely to be to have had enough of the spraying.

IRS Targets

There are two steps in making targets for spraying. First, an ideal target is arrived at and then assessed for logistical practicality. Then resources are mobilised for the practical target. Usually the attainment in the IRS is about 83%-85% for the whole province.

Complete coverage has never been attained because it is not practical. Some buildings/housing units cannot be reached. Other household heads refuse. Reasons for refusing include:

I. Educated ignorance especially by the urbanites
II. Fears that the sprayers could steal
III. Fear that spray operators allowed to enter the house might discover things the owner would want to keep hidden such as witchcraft tradecraft, government trophy e.t.c.

Geo-coding

This was done only at the start of the ZISSP supported IRS in 2010. Geo-coding has not been done since then. Base maps were provided from Lusaka. Then the spraying team captured the geo codes of the structures using handheld Global Positioning Receivers (GPS).

Challenges of eliminating malaria

- IRS should be complemented by other vector control methods such as Larviciding, ITN distribution and environmental modification. Since the Cubans left, larviciding has not been done.
- Partners do not always honour their pledges. So not everything that should be done gets to be done.
- IRS is very expensive. It would be difficult to spray continuously without ZISSP support.

Sinazongwe: FGD notes with NHC members in at Rural Health Center

1. 6 NHCs represented, trained under ZISSP in 2011, NHC were supposed to meet weekly but weren't active before the training.
2. When they became a NHC member: 2009, 2007, 2011, 2011, 2011, 2011
3. Gender balance in committees: half/half, 3 women and 7 men, 3 women and 7 men, 5 women and 10 men, 5 women and 6 men, 5 and 5. *Any changes in these gender ratios since ZISSP training?* More balanced.
4. All were selected by headmen and community, the communities voted for them. They get respect from having this position.
5. They meet together at HC; to discuss certain issues, meet with the EHT, 2 to 3 x month in community, once a month here at HC. NHC chair calls those meetings, EHT calls us to HC. We walk or borrow or rent a bike to come to HC. *How far from your homes to here?* 2, 5, 6, 7, 8 km.
6. ZISSP training in 2011 was on guidelines for NHCs, how to make action plan, 6 day training. There was a different training from World Vision in 2008, on FP, HIV, RH, nutrition, malaria, 1 week long. Most of these NHC members are also chw and so got this training. They also teach about FP, HIV/AIDS, learn about health problems in the community and report them to HC, meet as a group and discuss, work on sanitation issues (toilets), hygiene, managing rubbish heaps. They lack transport, identity.

7. Not asked
8. They fill out monthly report forms, when and outbreak occurs (eg cholera) they come and report it, not recording any feedback on patient satisfaction.
9. From HC they are given report pads, chlorine, advice on how to educate.
10. They are aware of some other community health workers working where they live: TB DOTS workers, lay counselors, malaria agents are there.
11. Their main role as NHC members is to encourage people to live healthy lives. They also develop action plans, together then make one action plan; these action plans get embedded in the District Action Plan. Then that goes to PMO. How long between when you submit your action plan and you receive resources to carry it out? Made the action plan in July 2012 and have received nothing yet. Is this typical? From District to here, it's typical. Admin problems. Ask the DMO.
12. Other activities NHC might do: when we work we work all day, 12 hours. Meetings go from 8 00 to 14 00. Need some support for this time. During outbreaks, eg cholera, NHC members are utilized as health workers too. Refresher courses would help. They did take part in a refresher course in 2012, on action planning and guidelines (I think this was ZISSP).

Recently trained 5 smag trainers for Sinazongwe in Livinstone, 1 from district and 4 from specific HFs that will have smags associated with them. Now going to do the community pre assessments at the 4 HFs.

This includes who to be trained, community sensitization about the coming smag program, and conducting a simple baseline (Beatrice, can you add?). He will spend one day with each HF.

Then will spend 2 weeks training a total of 80 new smag volunteers, 20 per health facility. Will run 2 workshops concurrently to be cost effective.

Eridge directly trained 1 training facilitator and 2 master trainers for Kalomo.

Re lack of materials for SMAG volunteers trained by Mumuni, he says he should involved ZISSP to be sure that the quality of the bags and other materials is consistent.

Smag volunteers get some transport stipend during trainings. 60 kw per day for transport and food.

Re-sharing of bicycles, supposed to be one bicycle per 2 smags in same zone. This is the zissp strategy.

After trainings smags in sinazongwe, he will go to kalomo to train drama groups under bcc. Zissp has done many, but this is first in southern province. ??

He has been training with Esmart. Beatrice requested trip reports and training reports.

He showed us the BCC training manual, the field appraisal checklist, an action planning handbook for districts, a planning book for district planners, the BCC Framework 2011-2015,

Noted other partners engaged in developing framework, including CSH, NAC, MAMAZ, MACEP.

At quarterly meeting ZISSP decided to reduce # of HFs being supported, concentrate on fewer to show more impact. Want to provide full package of support at these sites. DID ZISSP mention this in lusaka? need to find out more about this strategy, whether reflected in reports to USAID.

We asked about HFs waiting for equipment from ZISSP. Per Eridge, equipment is part of whole support package but is provided by other partners, especially CDC and BU in this province. His understanding is this is not ZISSP's to do.

Showed us the RLG materials A listener's Guide to Safe Motherhood in Communities, the RDL Program.

We suggested that laminating the action cards would be useful.

We asked about transparency in budgeting. Eridge shares his budget for specific activities but not whole budget. He has also looked at ways to share his trips, share monitoring, invite provincial staff along.

Reduced #

First Meeting with DMO, CC Officer, Information Officer (Hamalala Clareo?) and District Nursing Officer (Edith)

SMAGs are not yet here. There are some HW on retention scheme. HCACs, some active, some not. ZISSP has supported IMCI trainings for chws. ZISSP also trained NHC members early last year in 5 facilities. Selected 2 people per neighborhood for 6 zones. Sinazongwe has 13 rural health centers.

Did a training of trainers.

The visit a HC, call the NHCs, 5 were trained, but only 3 concentrated on (Simalima HC, Sinazezi, Siatwiinda)

They have been told that the retention scheme is being phased out.

For last year's action plan ZISSP played a major role in training for planning with CHC Eridge, he called meeting with representatives of communities and trained them in planning. Also did a training last year on community IMCI, but in Musaka not Southern Province, for chws. (Something about Simalima)

When planning, they call the stakeholders meeting, give us these ???, supported by ZISSP, include them in the District plan. Provincial planning takes place July and August, they organized training of NHCs on planning, roles and responsibilities including coming up with action plans.

Later came the CHW training.

There is a malaria officer in the District.

There is one nurse trained in LTFP, Mabel Melaya.

ZISSP trained 2 people in QI, but have not yet formed a committee, must organize this with Mambe Hospital.

Also staff from HF were trained in QI: Matilda Misho, Dolorosa Mombodwa inSeretende, also one in FP.

Can meet with clinical care team when go to Mamba Hospital.

Kumbutso asked for standard indicators for 11 sites on the list and for malaria information.

The Human Resources and Administration Head Was Away on Other Duties. Interviewed the Assistant Veranus Banda.

- Veranus Banda was quite new and doesn't fully know the trainings that staff have been given by ZISSP.
- She has not been trained by ZISSP in any way
- Feels the effects of the ZISSP systems strengthening activities on the operations in the district but HRA unit has not been a direct beneficiary
- Not aware about the trainings conducted by ZISSP in the district including the district office, communities and health facilities. The HRA office only keeps names of personnel, their bio-data and basic qualifications recognised by the Public Service Management Division. Information about the trainings conducted by ZISSP is kept by the Officers in-charge of the programmes.

Zambia Health Worker Retention Scheme

She has been involved in suggesting names to put on the scheme. At the beginning of the scheme, health providers in five health centres (Sinafala, Chamwe, Bbondo, Gwembe Valley Hospital and the District Office) were eligible for the scheme.

This year, the people managing the scheme came to the district and suggested that more centres should be included. Since Gwembe is a hardship district, all the ten health centres would be included on the scheme. Apart from the hospital where only the doctors are eligible for the scheme, all the health care personnel who typically comprise of a nurse and a medical assistant would be eligible for the scheme. In addition the health provider personnel at the Hospital Affiliated Health Centre would not be eligible to be put on the scheme because the doctors serving it come from the hospital and it is only considered a hardship posting for doctors and not for health providers such as nurses.

Currently there are ten health provider personnel on the scheme in the district. These are two out of three doctors at the hospital (the current District Community Medical Office recently returned from training and has not yet been put on the scheme). Other health providers on the scheme are from the following health centres:

1. Bbondo
2. Chamwe
3. Lumbo

4. Sinafala

An additional 13 health providers have been recommended to be added to the scheme.

She has learnt from personnel currently on the scheme in the district, that it took about one month to be put on the scheme.

The district HRA office is the liaison between the providers on the scheme and the management of the scheme at the Ministry of Health. Payments for the scheme are made directly to the providers. The HRA at the district does not monitor these. Currently, they have received no complaints about delays in the payments. They believe that the payments are up to date.

Things which make it hard for staff to be retained:

1. There is no electricity and running water in the houses provided to personnel at rural health centres
2. Roads are impassable during rainy season except to vehicles like Landcruisers
3. There no mobile network coverage in most remote rural health centres
4. Poor communication has been worsened by the breakdown of radios that were used to communicate with the rural health centres. It looks like they are irreparable. The Ministry has since been advised to replace them with radios operating on a different frequency from the one they were using

Over next two years, things which can improve the livelihood of health providers are beyond the reach of the district or the Ministry of Health. What would help to retain health care providers in rural areas would be:

1. An improvement in the living conditions such as provision of electricity and running water in houses
2. An improvement in the means of communication such as transport network, mobile network and advanced communication radios

Gwembe Valley District Meeting with Planner Mr Kellons Mutambo

The planner was new in the position. He recently returned from school where he had gone for further education in addition to his earlier training as a clinical officer with which he served in Gwembe District as a Clinical Officer.

1. Never heard of the Zambia Management and Leadership Academy
2. Trained by ZISSP in financial management for non-financial managers. This has really helped in monitoring financial resources and spending money strategically
3. Trained in data use for various aspects by ZISSP
4. Takes part in the Quality Improvements (QI). This is a new thing at the facility and it is not yet fully running. They have had five meetings so far. Formed committee and developed questionnaire to be filled in by personnel at district office to identify issues to be improved on.

ZISSP involvement in Planning

ZISSP supports the district in developing annual action plans. ZISSP supports the development of action plans. ZISSP plays a leading role in launching action plans at the start of the planning cycle about June every year. During the launch ZISSP specifies the amount of money they will spend on activities in the district and on which activities. They also help to leverage resources from other partners and to prioritise issues to be addresses in the action plans

ZISSP has also strengthened the bottom-up approach in planning which the Ministry of Health has been using to develop strategic and annual plans by training neighbourhood health committees and other community based groups. ZISSP has also supported the groups to meet with their communities and their health facility personnel by providing refreshments during meetings and paying the members of the committees some allowances.

Performance Assessment Tool

The PA for the district is done in two phases. In the first phase the district assesses itself. Then it is assessed by the Provincial team. The action points from the self-assessment and the provincial assessment are then consolidated. Parties to implement them at various levels are also identified. The recommendations from the PA and the indicators from the HMIS are used in the quarterly revision of the annual action plans.

For example in the February 2013 PA it was found that;

1. the district office did very few outreach activities
2. malaria cases were 44% of outpatient cases
3. percentage of children fully immunised was 64%

In response the district office has;

1. increased the number of outreach services in the revised plan
2. increased immunisation campaigns
3. intensified IRS and ITN distribution and related BCC
4. been offered TSS and will in turn provide TSS to the facilities

Due to capacity building by ZISSP and oversight from the provincial ZISSP team, the planning unit is now capable of monitoring the activities of the neighbourhood committees. When the Grant for the district is received 45 per cent of it is proportionately allocated to the health facilities by the size of the population of the catchment areas. The facilities then disburse 10 per cent of the amount they are allocated to the communities in their catchment areas. The planning unit assesses whether the communities used the money for the activities in their annual plans by reviewing the items described in the retirement reports and receipts.

Recommendations

1. They are lobbying for ZISSP to continue supporting district integrated management meetings where partners and facilities come together.
2. More assistance on systems strengthening and management support
3. Strengthen capacities in communities for them to appreciate the planning process priorities and constraints in resources to implement activities

Gwembe Key Informant Interview with District Health Office MCH Coordinator – Ms. Jestina Kafunga

Progress towards results:

Training: ZISSP supported and were listed as follows – all conducted at provincial level:

1. Long term family planning conducted in June 2012 where 4 were trained including her (DHO MCH Coordinator).
2. Adolescent Reproductive Health, in June 2012 with 4 including her being trained during the first training and another 3 trained during the second training.
3. EmONC – staff trained recently, but not so sure if ZISSP supported or RBF. Staff was drawn from four health facilities; Munyumbwe RHC, Chaboboma RHC and Sinjera RHC and the district hospital. 2 staff members were trained from the hospital – CO-Mr. Chewe and Midwife – Sarah Kachesa.

Training Manual/guidelines: She has seen standard operating procedures; QI revised manuals – protocols not yet sent by the province; Mesoprostol guidelines – being used at the district hospital where program is under pilot. Remaining centers do not have this document.

Activities: The following activities are happening: Mentoring is being done; supported radio program for safe-motherhood through radio Chikuni, a community radio station; supported measles campaigns; community mobilization; and ZISSP did conduct an equipment needs assessment.

Volunteers: Work with TBAs, but no longer conducting deliveries, they just escort pregnant women to health facilities. Have not trained SMAGs in the district and as a result, the district still have a lot of home deliveries – this is coupled with the bad terrain and limited transportation especially during the rainy season. No maternal waiting homes except for Munyumbwe RHC – which was built by government and where mother come as early as 32 weeks of pregnancy.

Changes Seen:

Mentorship – most facilities have no midwives. The ZISSP funding has allowed travel to sites to mentor these nurses

Gender issues – not to my knowledge

Community care improvement – is happening. Centers under ZISSP support have trained NHCs who are very active. Eridge – ZISSP has always provided support to them and other community volunteers.

ZHWRS: Not so sure of this.

Integration- Happening a lot during outreach. All services are given at the same time more than before ZISSP. HIV/MCH is no longer a problem – it is now policy in Zambia – PMTCT opt out. If mother test positive, given AZT at ?? weeks and Nevirapine tablet kept and taken during onset of labor. If delivered at home and with no Nevirapine, advised to come to HC with 72 hours. Child is put on Nevirapine syrup for 6 weeks. PCR testing is done – collected dried blood spots samples which is taken to Monze as central collection site by motorbike and eventually taken to Lusaka where the PCR machine is.

2 Years from Now: One of the biggest problems in the district is the lack of SMAGS. ZISSP should train SMAGS in order to support reduction of maternal deaths currently being experienced in the district. The bad terrain makes it very difficult for pregnant women to get health facilities especially during the rainy season. No ambulances are available at health center level.

Seconded staff: These have been building staff capacity in clinical care, management and community mobilization. The PA skills have been instrumental in giving guidance in improvement of provision of quality health services and increasing access and utilization of services. For example, Dr Nancy and Maureen have provided good training in end user's evaluation of data and now staff is able to analyze and make use of it.

Key Issues to Consider before ZISSP ends:

- Clinical care specialist: Very few staff is trained in IMCI and ZISSP needs to train more in this area. Most of the health centers have no clinical officers, usually run by nurses who sometimes are straight from school with no experience – therefore, this skill is critical.

- Management specialist still needs to continue training and providing support to new staff.

- Eridge – community coordinator should help to revamp the RED strategy so that children are fully immunized.

- Gender- We have seen more women moving taking up leadership roles as NHC chairpersons though not yet balance with men due to the low literacy levels among women, with majority of them not have confidence to take up leadership roles.

Documents Seen: Electronic EmONC guidelines

Gwembe One-on-One interview with Staff who Received ZISSP training

Mr. Chewe Samuel, Clinical Officer was working at Chisanga RHC as a clinical officer until 5 months ago when he was transferred to Gwembe district hospital. While at the RHC, he was trained as a CHA supervisor and he provided supervisory support to 2 CHAs. He still provides support to the CHAs on phone as it has been difficult to visit them due to lack of transport. He was also trained in EmONC through RBF funding. The CHA supervisor training has enabled him acquire new skills in supervision and mentorship. The CHAs have been at that health center for 10 months now – came in July last year.

Key Roles and Responsibilities: He provided ongoing monitoring and evaluated their work on monthly basis. He assists them set monthly goals and on an ongoing basis resolve issues related to work as they arise.

Rating CHA performance: Generally the CHAs have been performing well, although their work has not gone without challenges. The bad terrain makes it very difficult for them to move from one village to another, especially during the rainy season e.g. streams overflow making it hard for them to crossover to other parts of the catchment area. Although the CHAs have been given bicycles, households are so scattered making it so difficult to reach the household members. It is also hard to find people at home during the rainy season as most people go out cultivating in their fields.

What is done on a normal supervisory day: He would sit down with the CHAS to review the work for the day. Usually they are at the facility on Tuesdays and Fridays and community on Monday, Wednesday and Thursday. He would then see patients together with them, while providing hands on mentorship. He also participated in outreach activities and continued to provide supervisory support at community level. The CHA salaries took longer to arrive, but did receive the money in April this year.

Topics Covered During Training: Registers used by CHAs, expectations of the monthly supervisory visits, how to set goals for the CHAs, the roles and responsibilities of CHAs – dos and don'ts. How to structure CHA work, and field administration of drugs – all oral drugs but not injectable and IV drugs at facility and community, and CHA contracts – how they are paid and when to be shifted to the GRZ pay-roll.

Other Skills Acquired: Planning, administration including conflict management, clinical mentoring, data management e.g. knowing the catchment population, making plans to divide households or cluster households according the visits the CHA will be making in a month and the 2 CHAs sharing the villages/households.

Support from ZISSP: None provided from the time he was trained and has not yet received any supervisory tools since his training a year ago.

Zambia Health Worker Retention Scheme: He has heard about the scheme but not registered as the facility he worked at was not eligible. He has heard that people sign contracts and work for the specified contract period – only allowed to move out when the contract ends, and receive additional entitlements such as top up on salary.

Recommendations to ZISSP

- ZISSP and the DHO should provide supervision to trained CHA supervisors to ensure they are doing what they are supposed to do. The District does not seem to know or recognize the role CHA supervisors – hence not support is rendered and no funds are apportioned for CHA supervisory visits.

- Materials used by CHAs such as stationary e.g. for reporting should be made available.

- Transportation for CHAs must be looked into, for example, the bicycle break so often due to the bad terrain. Provision of motor bikes would be a better solution.

- I have heard that the recent training in Ndola covered a topic on conducting deliveries – and that the CHAs will now conduct deliveries provide injectable family planning method. More supervision and mentoring will be needed.

- If provided transport, I would continue providing physical support to the CHAs other than just by phone – despite being at the district hospital. There is also a District Supervisor for the CHAs who also lack transport to go and supervise the CHA supervisors. This aspect of the program requires improvement.

Health Management Information System

Trained in DQA

Trained in checking for data consistency by comparing with various registers and other consistency checks.

Use data to prioritise areas of intervention and areas of high impact. Have partially started using this training. However, they haven't received the mini-plans. From the programme heads for review by committee. Now unlike before will use data to assess the plans from programmes

ZISSP also trained staff in Epidemiology assessment using data. HMIS did not attend but the Hospital Information Officer attended

Due to the work of the management specialists, there has been improvement in the quarterly data returns coz the programmes people appreciate their own data. Nowadays they are in the forefront of ensuring that all suspicious data is investigated.

1 May: Munyumbwe Rural Health Center - Health worker on retention scheme, George Mutakwa, EHT

Questions from one on one interview for hw trained by ZiSSP, Section Two:

7. When were you on the retention scheme?

Before came here, from Chaamwe Rural Health Center, he was on the scheme from October 2008 to last December 2012.

He received a salary top up, but not regularly. It was skipped some months, but then it was made up in arrears, so he eventually got the payments. It was always the same amount. He didn't receive any other benefits.

He said that people in the DHO didn't have much information about the scheme; the payment came from Lusaka. When payments were late, he didn't ask any questions, just waited.

8. He thinks the scheme is managed pretty well, and that it's a good motivation factor for people to stay in remote posting. He was the only person working at the Chaamwe RHC when he received the retention scheme payments.

9. The payments were late about 3 times over a period of more than a year.

10. He thinks the amount of money was sufficient incentive; he has a family. However, the biggest problem at that posting was transportation; the hospital didn't have transportation. A vehicle loan would have been helpful.

Any suggestions for the ongoing management of the retention scheme?

Instead of money, might be better to provide things people need most in remote areas. Transport is the biggest problem for health workers in remote postings, so a vehicle loan might be more useful than the salary top up.

Right now there are no staff at Chaamwe where he was previously posted because of the transport problem.

The smaller rural health centers don't get MOH vehicles. A loan would really help.

SCHEDULE OF INTERVIEWS at Copperbelt PHO
23rd April, 2013.

SLOT A				SLOT B	
Time	**Title**	**Name**		**Title**	**Nam**
08:30	*Senior Accountant*	Mrs. Nalishebo Mvula		*PNO – Maternal & Child Health*	Ms. C
09:30	*Clinical Care Specialist – PHO*	Dr. Lyapa Sikazwe		*ZISSP - Management Specialist*	Muso
10:30	*Ag. Health Information Officer*	Mr. Kingsley Kapemfu (would like to be interviewed with Mr. Mulendema)		*ZISSP – Community Health Coordinator*	Mrs. V
11:30	*Senior Health Information Officer*	Mr. David Mulendema		*ZISSP – Clinical Care Specialist*	Dr. C
14:00	*Senior Human Resources Management Officer*	Ms. Florence Kashita		*Laboratory Provincial Focal Person (on ZMLA)*	Mr. N
15:00	*Provincial Information, Communication & Technology Officer (CDC supported)*	Mr. Sam Phiri			
16:00					

Note: for the position of Data Management, the province has two people who perform different functions. Mr. Kingsley Kapemfu has been appoint to action in the position of Health Information Officer at the PHO. Mr. David Mulendema whilst being the Senior Health Information Officer deals more with the planning unit and reports (he is to be retired soon). It is for this reason that Mr. Kapemfu would rather be interviewed with Mr. Mulendema who has been at PHO longer and is senior).

Mumuni, Brian Mulwani, Finance Officer Joseph Nkausu, Field Manager

They were given ZISSP grant toward end of year, they started training in December, finished in February, so real monitoring and support supervision might not have taken place, just beginning to move into that area. Haven't yet received the funding for M&E, have not been in the field to see exactly what is happening however, they have arranged 2 possible places, if we finish early with community in Namyanga, want to catch up with EmONC person, finish by 11. They are the main areas of operation, have started reporting. The most active center so far is Sikonazova, too far away. Tomorrow only EmONC trained, will take you around, talk about data management. We could split, Kumbutso can do one on one, she does the checklist, I work with Flannel to FGD.

1st meeting with ZISSP Sr. Management team Monday 8 April 2013:

Kathleen Poer, COfP; Dr. Elijah Sinyinza, Dep COP, Kasubika Chibuye, Dir of F&A; Nanthalile Mugala, Director of Tech Support

Introductions, The team requested project organogram, seconded staff contact list, list of grantees,

Overview slide presentation, also have presentations on each program area. Programs for support at central level, etc.

Project duration 7/10 to 12/14

Contract not CA, cost plus fixed fee contract, base funding is $88 million

Expenditures $47,524 to date.

Abt prime, Akros Research malaria, ACNM EmONC and MNCH, BRITE management and leadership training, JHU CCP HE and BCC, Liverpool School of Tropical Medicine malaria, research methodology and M&E/entomology, PPAZ FP/RH

2 local entities: BRITE has registered as local and PPAZ.

In original design Banyan Global their original focus was on public/private partnerships; USAID already had a project CHAMP that had established partnerships for Global Development Alliance, private partners not interested in other arrangements with Banyan. USAID was disillusioned by GDA process.

They started and succeeded but took 18 months to get a GDA agreement in place. No contract amendment to drop them out.

Counterparts: MOH and MOCDMCH, Central ministry depts., NMCC, TWG, provincial and District MOs facility managers, CHWs, HCACs, NHCs, SMAGs

Related USG programs: ZPCT2 – HIV in northern half of country; Center for Infectious Disease Research in Zambia CIDRZ; Private Sector Social Marketing PRISM; CSH; JSI/SCMS and Deliver, SMGL multiple implementing partners – endeavor not project under GHI, Zambia and Uganda are 2 pilot countries. Jorge at USAID and Dr. Jim McCully CDC. USAID had no incremental funding, but CDC did gave in EP to CIDRZ and SP to BU. So able to implement new interventions, whereas USAID partners looking for opportunities to tuck this into existing scope of work, so concentrated more resources in core districts than otherwise would have, initial plan to form SMAGS and training in EmONC (?), ZISSP supplied districts with district coordinators to help various partners coordinate SMGL activities. The 50% goal was set in Dept. of State.

Meeting next week in Livingston where all partners for SMGL coming together. Too many people invited already. Both Uganda and Zambia are presenting, rolling out to new countries. Malawi is a new country. Next Tuesday is all partner day for SMGL in Livingstone.

Four ZISSP tasks: nice diagram to show levels: national Task 1, Province and District Task 2 many resources here, Community Task 3 much of this work is through the district rather than directly. 4th task: build systems and capacity and leverage resources and engage partners – integration and CB –

Have not exercised Option 5 regarding food/nutrition. Feed the Future funds for Zambia have been problematic because of macro issues, no national plan, etc. FF money has been slow overall.

USAID asked for HSS, but also asked for systems support including seconded staff and training, MOH asked USAID for personnel, MOH priorities are heavily focused on support for basic services.

Role of seconded staff is very challenging; in many places they are doing GRZ's job.

Rubics cube diagram for WHO HSS building blocks

In some areas where we work we do have a Systems Strengthening contribution but not in all; our role really is to support MOH in program areas and in provincial health offices.

CDC is funding programs to strengthen nursing training; they fund CIDRZ local NGO formed with CDC support, became lead organization and subcontracts to UNC for TS, have reversed roles.

When you read the contract, there is a lot about basic things like training, then we've tried to increase the trainer pool a more systems level intervention, help with curriculum revision, make training more efficient. **Adding a SS dimension to basic activities.**

SMGL 50% reduction "aspirational goal". This was foisted on the mission and on ZISSP. Was it formally added to contract? If not, what responsibility does ZISSP have to meet goals?

Context: project reaches across the whole country; project also covers multiple program areas, project also seeks to address all levels of the health system: central ministries, provinces, districts, facilities, communities. Some places where we're working may be a full day drive. Time for travel is significant.

Request for information on the facilities and communities where ZISSP focuses. **Yes, we selected focus facilities and their associated communities, will provide that.**

7 target districts, new districts are forming, some provinces are being divided. Usually when new district or province is being 'sliced off', ministry sees it as a parent and child relationship so ministry and **ZISSP role is to continue to support both**.

Work in communities is focused mostly on Task 3 activities. We tried to focus more to a smaller group of 10 districts, so one key district per province. How were districts selected? ZISSP made proposal, vetted by?? TWG, thought about how it would impact other programs, balanced among provinces, NP had 12 districts, so chose 4, Lusaka had only 4 districts, so allotted 2, others got 3. Equity was principle. 4 criteria: ranking of district on League table, simple metric used by M with 10 key indicators to compare districts; a ranking system to show availability of HR in relationship to establishment list, desired staffing and sufficiency; presence of other partners; and one more.

Were any former HSSP districts? **Selection bias was to get the worst, lowest rank on League table and with fewest partners but with sufficient HR so possible to do CB**. At same time WB was planning a RB financing program and had selected 18 intervention districts and 9 control districts. Some part of HC financing working group wanted no overlap between WB and ZISSP districts, making selection difficult. In end ZISSP ended up overlapping evenly with WB in terms of locations of the RBP 2 groups (2 types of packages in WB project, one with more robust funding) and the control group. In WP PHO insisted on certain districts.

The team requested a copy of target district selection report. Given that districts are lowest performing in many cases they are also hardest to get to. In new province, Muchinga, government gave them a district that doesn't have a connecting road.

More context – health system:

High levels of Maternal and Child M and M, malaria, high fertility rate, high stunting rate.

Highly centralized personnel systems for all government (recruitment happens through cabinet office).

HR information systems also highly centralized.

Insufficient production and uneven distribution of HR to meet management and facility needs.

Rural areas often thinly populated.

Retention of trained staff is a challenge.

Personnel transfers are frequent and not always well coordinated (central management systems); people may go to training program, their own DMO may not know about it. **Problematic communication channels, not all flow through normal hierarchy. Challenging for this projects with its big emphasis on CB.**

More about this in the HRH discussion. ZISSP is doing an assessment now about how well the retention strategy is working. ZISSP is a contributor to the pool, reimburses MOH for portion of people who are on the scheme. Way to transfer resources as a reimbursement, funds go to MOH rather than flowing through M o Finance.

New MCD/MCH. Got a new mandate with new government, which is MCH.

New provinces (1) and districts (20 plus).

In 2009 donors suspended contributions to basket funding mechanism. Caused a contraction in financial resources for health, especially at district level. In last ¾ months, government and donors signed a framework to create a foundation that will enable donors to begin to contribute again. Due to a GF audit that found many concerns.

G to G mission is here, led by Deloitte, trying to figure out how to do direct government funding. UNDP is proxy prime recipient on behalf of MOH for HIV grants, malaria, TB.

ZISSP does no HIV/TB programming. USAID's TB investment is through other IPs.

Big function of this work is to strengthen planning processes, but one of the challenges is that districts have maybe ½ to 1/3 of prior funding because of cessation of basket funding. The team asked if there were any data about this as a key contextual factor and will ask about this at the provincial and district level.

Work to support and strengthen systems for planning, implementation, monitoring – districts plan based on indicative budget figure, then population grows but budget shrinks and/or flow of funds is not reliable. Don't receive regular and even tranches. K: in last 2 years, financial reports show

nearly 100% funding in budgets, that government is better keeping its commitments. But districts will say our grant didn't come for 2 months, just now receiving it. K: you see the yellow books, Form C. What is allocated is being actually committed. But it sounds as if they are not getting funds in timely way. They may get nothing in two quarters, and then funds for all three quarters at a time.

Context: Capacity Building

Big needs for in service training to address new and evolving programs while pre service curriculum revisions lag and also for providers already in sector. HIV hasn't been fully integrated into pre service curricula yet. Do medical universities play any role in in service training? WB made agreement with a provider organization as a training resource for their RB financing program. Some universities do train nurses? Worker mobility and attrition are issues.

Highly centralized system to approve training – PS signs off on every training invitation letter. Trainers are often also employed at the central Ministry level – insufficient number of PHO led trainers in many areas.

Trainers are MOH or MCH staff members who have many other responsibilities – constant tension between their role as trainers and other job responsibilities. A mixed blessing is that project is working with pool of trainers who are MOH staff with demonstrated technical competence who become part of the pool of national trainers. But there is no JD that says they are only trainers; they have other duties as well, so **hard for ZISSP to find trainers who are available to assist with scheduled trainings. Not enough HR to have dedicated trainers, clinicians are needed for clinical services.**

In service training financial and opportunity costs are high: recent increases in Daily Subsistence Allowance have doubled or tripled in service training costs (from 300k to 600/700/800 k per day depending on location and your level in system); most ZISSP trainings are long (20 days); in service training exacerbates staffing gaps in HF and management offices that are already understaffed, people away for training can't always be replaced; HR shortage means some project seconded staff lack counterparts for on the job CB. So they are just doing the job.

ZISSP has reduced level of training output due to cost increases, are there other strategy revision options?

MOH Structure:

HO: Statutory Boards, National Training Institutions, Tertiary hospitals

PHO: second level hospitals (general) and trainings institutions and DHOs

DHO: first level hospitals, health centers and health posts (they are responsible for HCAC and NHC) MCD will assume responsibility for Primary Health Care

In next 18 months before ZISSP ends, will MCD structure be fully functional? At central level, yes, but P and D levels will take time. In many instances, ZISSP counterparts have been transferred to MCD. Has caused some disruption. **At district level, DMO is calling himself District Community Medical Officer,** same people, essentially same office, but reporting not clear.

(How often) do DCMOs come together on a regular basis? Yes. For sector advisory meeting, all PMOs would come for that. If big launch happened, they will all come. **The national planning launch in next month and a half, date not yet sent, hoping could happen before end of May.** In terms of distributing instruments, ZISSP people in provinces could help. All ZISSP staff have email but also have connection challenges. Also don't have courier options in all districts. Focus on 27 target districts could come up with quick plan to reach all, or ZISSP can help disperse them through provincial staff. Getting back through an independent channel will have to be thought through. Do you bring your own people together periodically? Yes, mid May. That would be highly useful for interviewing the seconded staff. Also site surveys, if we structure it to have FGD.

Requested JDs for 3 seconded positions and 4 District Coordinators for SMGL.

ANY POTENTIAL ROLE FOR ZISSP IN FACILITATING BETTER COMMUNICATION AND COORDINATION BETWEEN THE TWO MINISTRIES? Absolutely. We can kind of be a broker, unless the two PSs are talking to each other, for example MCD should be taking a stronger leadership role in planning cycle that is coming up, we were saying why don't we bring planners from MOH and have a brainstorming and also discussion of how roles of different entities are going to articulate in this cycle, they liked the idea of joint discussion and that ZISSP could be broker to make the request rather than having to come from a PS, which takes longer.

Liverpool and ACNM are not physically present in country. Next week ACNM will be in Livingston to do back up support for a training will be there when partners meeting happens. Would be good chance to meet with them and observe them. KP will provide the agenda. It's a bit high level.

6 hours driving to Livingston. And there are frequent flights. Maybe $500.

ZISSP seconded staff:

MOH or MCDMCH staff – formerly at MOH and now **1 HR person is still at MOH, others to MCD MCH (4) NMCC (6)** – central level positions all filled.

Abt is prime contractor another malaria indoor spraying in Zambia; there is an activity funded under that mechanism and one seconded person for that.

Districts for other project are Eastern, Muchinga, Northern. So **only Nyimba overlaps**.

PHO: 7 CCS (recruiting 2 replacements), 9 MS, 9 CHC, 18 Logistics Assistants (driver and F&A support)

DHO: 5 SMGL coordinators, Active Case Surveillance Officer Lusaka

Gates is funding similar malaria project; our partner works on active case surveillance and their partner as well. Little pilot in Lusaka has given them the information they needed to design activities rolled out much more widely in Western and Southern Project with Gates funding.

Reason for 5 SMGL coordinators: 2 districts in EP; one is in PMO from EP asked for a coordinator at provincial level. Maybe interview the coordinator in the provincial office? PMO is a role model, excellent.

Malaria component of ZISSP could be a project in and of itself. Predecessor to AIRS project wasn't renewed in time, predecessor to ZISSP had a malaria component, maybe had there been a global mechanism available they would made a separate project.

Reason mission put this work in contract: there is good complementarity on technical side, but also competed all 4 major awards at same time, mission had a lot of on its plate, needed to find a place for the malaria work.

ZISSP project will end in December, right in middle of spray season, need another mechanism to continue the spraying.

Seconded staff are integral participants in the Ministry planning process at all levels. Seconded staff do belong to the MOH MCD-MCH or PHO. Sometimes we have competing needs, most often in malaria, structure of malaria program changed; in past ZISSP support was in training cycle and MOH used WB resource to fund operations. But many funding delays so decision made by PMI that in order to protect investment, would select smaller number of districts and be responsible for IRS aspects, case management ipti in more than 20 districts.

Follow up to training differs, done by trainers for EmONC and?? using resources from ZISSP. May come from central or provincial level. In case of malaria case management, what we were working on was to orient them to revised guidelines, more to update them on what changed in most recent treatment guidelines, a lot of follow up happening through CCS and CCTs.

During annual planning process, ZISSP staff look for places where MOH priorities match ZISSP priorities and weave ZISSP support into HQ, PHO and DHO plans. ZISSP annual plans are guided by and shaped around MOH priorities. Looking for convergence, how our activities get woven into their plans. Our activities are perceived as part of the ministry activities, not separate. There are challenges to that: because our activities are already woven into plan of the ministry, we get our activities integrated in their plans, that's' basically a good thing. We are in a lucky position because of that. If a ZISSP activity is not seen as a priority in a district, probably won't be implemented in that district.

Planning is May. Cycle is June to August. Presentations to budget September. Long process.

What about ZISSP's phase out strategy in that planning process? Are you thinking about that yet? Planning process doesn't depend upon ZISSP, our support will be diminishing in some areas yearly. So this planning cycle will focus on what ZISSP will do in 2014. We **plan on calendar year cycle, to match government's planning cycle.**

CCS – under prior project HSSP, concept was introduced and MOH did incorporate that position into its establishment list and now has this position at provincial level. MOH still requested that USAID continue to fund CCS, have a wide domain, our objective would be to have a dialogue about position of CCS and MS to know whether there is a clear role for them to argue for the gov't to incorporate them.

MCD does have infrastructure on the ground in communities, so CHC position becomes a more living concept. This could be a role to be assigned in DHOs or otherwise located. ZISSP knows it needs to have this dialogue with Ministries.

With embedded staff project better able to understand and align with ministry priorities. Difficult to capture effect of embedded staff in building capacity with counterparts.

Personnel work as seconded staff and try to avoid being totally engulfed in daily tasks.

Seconded personnel seek to strengthen the ministry staff capacity and MOH systems in order to improve overall health system performance.

Does ZISSP have any CB milestones or measures? Haven't designed milestones or measure for CB being built by seconded staff. for ministry staff trained in particular areas, follow up process is to observe use of new skills.

Seconded staff do have work plans in terms of what they will do with their counterparts. Is part of annual appraisal process for staff. Most seconded staff have specific program goals that they are accountable for over course of year. For example, a CCS would be asked to support formation of clinical care team in agreed upon number of districts.

Do other projects in Zambia place seconded staff in PMOs? A lot of projects have data clerks placed in HFs to capture micro data that PEPFAR requires. But not like the ZISSP positions. **CSH has central level seconded staff, in health promotions office but has moved with team to MCD, also have someone at NMCC.**

Seconded staff try to maintain role at higher systems level but get engulfed in doing daily tasks as well mostly because work load is so heavy.

If ZISSP goes away, would that pull out pillar staff and create difficult vacuums? ZISSP knows it needs to start a dialogue especially at provincial level about roles of MS and CHC to determine whether need to lobby for their inclusion in entitlement list. Put this in the COP questionnaire.

We are interested to hear your comments on pros and cons on that, decision to incorporate them into entitlement list is made in the Cabinet.

ZISSP staff in Lusaka HQ

Sr Man Team 4

Proram Team Leaders 6

Program Officers 6

M&E 3

ZMLA team 6

F&A team leaders 3

Finance staff 6

Admin staff 10

Logistics assistant

Task 1: National Level

Repeats what is in TOR. ZISSP has baseline report about TWG in each domain.

MS doesn't have a direct counterpart because that function doesn't exist in the Ministry structure.

MS working on improving clinical care, program performance.

In some provinces PMO has told CHC not fair to work just in 3 target districts, indicates value of role.

Management and leadership training program through BRITE for PMO and DMO team with quarterly short forma training sessions followed by mentoring. Focused on 27 target districts.

In past there was a good system for engaging communities in health planning, fell away after central board of health dissolved, priority of both USAID and ministry to revive it, good potential with MCD to revive it. CHCs focus on community participation in health planning and BCC.

Three people here in ZISSP who are JHU staff working on BCC.

District Level Malaria Tasks

Support in 20 target districts: skills building, refurbishing IRS storage infrastructure, strengthening supervision and planning for IRS and other malaria control interventions, improving malaria case management, expanding FANC to cover all districts, implementation of IRS.

Project originally supported 35 districts. Doing quite well in this, it's operationally complicated but things going well. One person who is a seconded staff member is an entomologist, but also doing CB of MOH environmental health technicians at HF and DHO or sr. environmental health officers (at PHO) to do basic entomological surveillance. Some trained and more to be trained.

Other project AIRS buys insecticide.

CB for malaria case management is not restricted to 20 districts; IRS is restricted to 20 districts, but ZISSP also supports management meetings. There is a twice annual process of Performance Assessment, Provinces to Districts, Districts to HFs, ZISSP has tried to improve use of this tool for problem solving. We always chose places with greatest need for malaria work.

Clinical mentoring, QI, performance assessment and technical support supervision as follow up to address problems identified, all are tools that can help identify problems in the supply chain that refer problem to appropriate level so can be addressed. CCTs can remind HFs to increase order. **TEAM SHOULD TALK WITH JSI DELIVER TO SEE HOW THEY ARE DELIVERING SUPPLIES HERE.** CHANGE IS HAPPENING INCREMENTALLY, **18 DISTRICTS PART OF ESSENTIAL MEDICINES LOGISTICS IMPROVEMENT PROGRAM (EMLIP**), eventual design is to transform whole system to 'pull'. Reagents are a chronic issue; JSI is one part of procurement picture but are not buying a sufficient quantity of malaria reagents for entire country for entire year. Various parties, some live up to commitments better than others.

Task 3: Community Engagement

CHCs work with community groups to build capacity for health planning, enable communities to develop local BCC plans based on a framework; support supervision for new community health assistant program, strengthen services delivered by CHWs by identifying and resolving gaps through PSAs?

Engage CBOs FBOs through grants to better integrate activities with health system.

Increase involvement of traditional and faith based leaders change agents for health.

Grants Program original plan to provide 30 grants to CBOs FBOs women led organizations to help build community ownerships for health and BCC. Where does grant funding come from? Grants and community activities draw funds from all sources.

Task 4: Engagement and integration

Written into all contracts awarded at same time to encourage IPs to coordinate well and leverage resources. ZISSP has fostered stakeholder meetings at district and provincial levels to talk about their activities.

One thing in contract not done as a result of guidance from USAID is to formalize any GDA. Need to get it out of contract. Where does PRISM fit in with this? GDA was formed around HIV with PEPFAR funding. There are 14 major partners to GDA. Took 18 months to sign agreement. USAID and IP for PEPFAR (COMETS, may be still operating under no cost extension) and the 14 partners said not interested in forming another partnership through ZISSP. Willing to be engaged in other health domains besides HIV but would rather mechanism through mechanism of CHAMP or COMET to do it.

There is some private/public collaboration with malaria, but hasn't been formalized.

Not long ago CHAMP formed a new entity, built on platform of first collaboration on HIV but to expand more generally to health, ZISSP hasn't integrated with it but that is the logical way to go about collaborating with the GDA partners.

Has government recruited a second cohort of community health assistants to be trained? 2nd group started their yearlong training in October. Numbers? DCOF will get numbers. In terms of their distribution, who decides? ZISSP not advising on this. They are recruited from communities, get trained, go back to their communities, ZISSP plays no role. Do have data on where the trained ones have been placed.

This is a government program that ZISSP has provided support to but doesn't manage. Major funding for the first cohort came from DFID, ZISPP's role has been to help fund salaries of tutors.

The team requested list of where CHA Supervisors are located. Child supervisors curriculum is a government curriculum.

Noted SMAG training, trying to integrate with HBLSS; are you looking at entire HBLSS curriculum or just integrating a few modules? There are about 20 modules in the HBLSS training, so far **12 have been chosen as main community conversations around which training is happening.**

For next consultations, request to see training curriculum and operational guidelines.

In every case where there is a national curriculum, that is what we use. What curriculum for CCM?

Health curricula are endorsed at TWG depending on technical area. Many guidelines are based on WHO guidelines, use global guidelines. ZISSP will work with MOH counterparts to adapt or revise for Zambia context, but are national training curricula used in nearly all training being done.

People selected to be members of NHCs have been trained as community volunteers. New cadre, CHA, is a paid position, hopefully were recruited from among people who were previously community health volunteers, there is potentially some competition between the two groups. Some people now being paid and others are still volunteering.

Training health providers who in turn train community volunteers for IYCF; training at community level the community members themselves. HF is usually staffed by one or two people, they conduct the trainings, either bring participants to district where there is training space or will do in community if there is a space for training.

Have people trained as trainers of SMAGs and also places where community members have been trained. 2 indicators for ARs – one about people who complete individual models, each model a different topic, then indicator about how many complete all 4 modules, attrition is a challenge.

Are there concentrations of people who have completed more training modules? A cohort from each province and cohort from each district (started with 9) will see one provincial and one district cohort for each province. SMGL data: Per K, just finished baseline last month, doing data entry now. Have changed language about SMGL targets, now an aspiration to motivate people.

2nd ZISPP presentation – Task 1 national level activities

Set up meeting to discuss training activities with Elijah and CB specialist.

HBLSS was part of original proposal from Abt to USAID that would work to introduce the method here, but there were already lots of things going on including big investment by UNICEF to develop a program manual for this. **Idea was how can HBLSS tools and curriculum help strengthen already existing effort to create SMAG program.** There is a logical complement in sense that SMAG program manual SMAG was lacking. Wasn't participatory training manual, no trainers manual, no Power Point.

ACNM has agreed to adopt the curriculum anyway, just put footer on title page saying this has been licensed for HBLSS use by ACNM. Since in the loop of revisions to protect legal copyright must insist on disclaimer.

Introductions: Program managers in meeting:

HRH Elizabeth Jere, HR Specialist, attached to MOH,

EmONC – Dr. Christopher

Child Health and Nutrition - Mary

Outgoing Team Leader - Dr. Muntinda XXX

FP and Adolescent Health Specialist on team not here today

HRH presentation – make sure these activities are reflected in questionnaires.

Requirement 59,998 HW but 33,900 filled as of 9/2012

Limited capacity of training institutions to produce required number and turnover and inequitable distribution

Who is working on strengthening HRIS?

3 key technical strategies

4. Adopt job based training and mentoring program?? CB in HRM, planning and records management
5. Develop modern HRIS: strengthen payroll management and establishment control (PMEC) System

Develop prototype of needs based HRIS for MOH

6. Support effective polices and systems to attract and retain staff and enhance staff productivity: ZHWRS, support implementation of new GRZ performance management package (PMP) and staff appraisal system
   PMP provides for accountability and development of management skills for health sector and larger GRZ

PMP introduced new GRZ staff Annual Performance Appraisal System (APAS), replaced old Annual Confidential Reporting System

Key Beneficiaries: MOH, OCD, health training institutions

*Major CB Activities

Reimbursed MOH for 119 HCW on retention scheme (out of 1,125 hw) as of 31 Dec 2012

Recruited ZHWRS administrator to provide TS to administer retention scheme for one year.

Beginning an evaluation to determine whether the ZHWRS is achieving its objectives (in terms of retention or health outcomes?) should have report by June. HW retention, tutor retention, contribution of MDGs.

TS and FS to DHRA for quarterly performance review meetings to assess and monitor annual performance against targets set out in HRSP 2011 to 2015.

Meetings led to better communication, increased team work, better planning, report, feedback at HQ, provinces, major hospitals and improved productivity in DHRA.

Request for copy of letter saying that ZISSP contributions have been significant. TEAM HAS LETTER.

Developed PMP implementation strategy, provided support to MOH to train trainers in PMP, trained staff in PMP, about 45% of MOH staff trained in PMP, add departments under HQ and some HF in P and D have started using the APAS. Continued roll out as result of trainers trained with ZISSP support.

All HW have individual work plans and targets agreed on with supervisors; never had before.

Conducted cap needs assessment for HRH Directorate. ASK FOR COPY. One of identified weaknesses was poor records management. Discussed problems came up with solutions.

Trained 53 HR staff, records management staff and registry clerks in HRM, planning and records management. Improvements in dispatch section, records keeping and tracking, MOH has since purchased computers for Registry Department at HQ to put in place electronic file tracking system to be rolled out to provinces in 2013.

Gave scholarships to 4 management staff at DHRA to Harvard course in HR strengthening
Have supported training of 770 health workers against life project target of 860 representing 90% achievement. Gov training facilitators have done the work, from Cabinet Office, TS division. Also for Rec Mgt.
Produced the HRIS report that described steps to enable the MOH to have direct access to PMEC data. ASK FOR COPY OF REPORT. This system not yet up and running. Encouraging Cabinet Office to bring this system over so it is decentralized. MOH must request reports from Cabinet Office. Cabinet Office has said will provide FS to decentralize the PMEC. In 2013.

Provided support to clean up payroll system, deleting staff no longer there, MOH was running parallel structures from old Health Board structure, now MOH, so have a payroll system with staff from old structure and from new structure, so have cleaned up and made current. Locked salaries = someone who absconds from their position, salary has been locked. Ghost workers. Ongoing issue.

Support to develop prototype of sustainable and standardized HRIs system. GRZ has expensive system, Cabinet Office came up HRIS to manage training data not yet rolled out to Ministries. Came up with needs for MOH and developed prototype which suits requirements. IT staff are developing system. Shows trainings, postings, staff who are confirmed, people due for retirement. ACCESS based, tailored to MOH requirements. IT says should have developed system in next 2 weeks, will need to be piloted in one province, then have TOT on how to use system, also developing a user manual. User manual, operational manual. WHAT WAS COUNTRY USING PREVIOUSLY? THIS SOUNDS AS IF EVERYTHING IS BRAND NEW.

Trained 80 provincial staff on WHO designed Workload Indicators for Staffing Needs (WISN) tool as step towards developing better health workforce plans. Used to determine workloads of HF, based on workload determine manpower required. MOH adopted this tool, ZISSP assisted the pilot. Piloted in Lusaka, trained 8 trainers, now piloting tool in 3 HF per province in one district hospital, one rural HF and one urban HF. In June or July will meet to learn results of pilot. Evidence based tool on how to determine manpower levels for HF. Trained staff have acquired skills and knowledge to effectively and efficiently plan for health workforce.

Key partners: Cabinet Office, MOH, MCD, MOLSS, PHO and DHO, CHAI - ?? collaborated with them especially on clean up of payroll system.

Questions:
# of reimbursements for retention, 119? Is this life of project target? **Where are they?** ZISSP selected the 119 from ZISSP supported districts. Concentrated on hardest to reach districts. With doctors, tend to find doctor per district. This is a special scale up plan to retain staff in hard to reach

areas. This is a voluntary scheme. **Part of ZISSP's work is to come up with sustainability plan for this for MOH.**

Are we measuring retention against contract period or some other number of years? Contracts are for 3 years. Have ZHWRS guidelines that say for 3 years. Evaluation will look at whether they actually stay for 3 years. When someone is posted, how often does DHO check to make sure they are there in place? Is there a tracking system? This is one of questions for evaluation, how is scheme being managed and monitored. What are monitoring mechanisms in place? Others in districts also want to go on retention scheme. Trying to encourage HR staff that monitoring these workers is part of their work. Will PMOs know about retention scheme. Most PMOs will understand scheme quite well, have been involved in past with this in previous Abt project. PMOs and also some DMOs have been trained in guidelines.
Can provide us with list of these retained professionals. Can ask PMOs and DMOs where to find them.
1125 goal for all scheme. ZISSP supporting approx. 10%

Would HCACs know about worker retention scheme? Is there parallel with what UNFPA does for training? Another strategy to ensure workers stay in communities, train community based residents and bring them home to work, they stay in positions for a long time. May be difficult to collaborate the effect of retention strategy. ASK HCACS about worker retention scheme. With the UNFPA system community members know how it is benefiting the communities.

She is working directly WITH DHRA and Assistant Director of HRA and Chiefs.

EmONC: Dr. Chris Nwande? RH Specialist also incoming Team Leader for MNCH

No EmONC training in 2005? Institutional deliveries low, 47% in 2007? Need updated stats.
PNC coverage low at 23% (also 2007).
ZISSP goal: contribute to reducing MMM by strengthening capacity to coordinate, plan, implement, monitor and assess national MNCH program interventions.

Key Strategies
Improve EmONC knowledge, skills and practices among service providers: strengthen EmONC curriculum, national training sites, support TOTs to increase pool of trainers, build capacity through training and mentorship of HW in EmONC, orient DHO managers and supervisors to EmONC to improve cap to support and supervise Basic and Comprehensive H Facilities.

Introduce HBLSS in target communities.

Advocate for strengthened MOH policy and program support for PN visit practices (is this a role for CHAs)?

Key Beneficiaries: MOH, MCD, Med and Mid/Nurs training institutions, Docs, Med Licentiates, Cos, Midwives, Nurses and tutors, clinical instructors, community members

Major activities: establishment of 2 national EmONC training sites, increasing # to 4, 2 new in Chipata General Hospital in EP and Kitwe CH in Copperbelt. VISIT THEM?

20 HW in TOT to increase trainer pool
National Standard: to have 1 CEmONC and 4 BEmONC sites per district – move this. DFID and UNDP provided emonc equipment last year and this year at selected sites. zissp does identify equipment needs before training takes places. Role of clinical mentoring to identify these gaps. Is there way to solve problem if there are equipment gaps? ***EmONC specialist is seconded by ZISSP participates in distribution of equipment and feedback from provinces re inadequacies and overall coordination among EmONC partners. to what degree has zissp helped to roll out fanc? That is under PMI will discuss on Friday. Strengthening the IPT primarily, trainings in IPT at HW level. Also focusing on HIV/AIDS, STI, have come up with training module to attach to existing one. (ASK TO SEE.)***

Oriented 18 DHO managers and supervisors in EmONC and MDR from 6 districts. ASK ABOUT MDR POLICIES AND PRACTICES.

Total of 18 target districts have been oriented in EmONC/MDR with support from Results Based Financing project, being funded by WB. So ZISSP has done 6 and WB has done 12. Will do others in future. Has there been significant shift in resources as result of SMGL that has caused more attention to be placed on the 4 SMGL districts? Certainly in training aspect. ASK MORE ABOUT THIS.

Trained HW in EmONC 253 against life of project target of 340, 74%, covering 33 districts including non ZISSP districts. Almost half have come from SMGL districts. What happened with EmONC and MN care efforts in the non SMGL districts as a results of shifting resources?

Supported post training technical support supervision (visits conducted by national EmONC trainers) to EmONC trained HW in 4 provinces. Developed tools for supportive supervisIon system for national EmONC training sites. ASK TO SEE TOOLS. Previously some training sites were not adhering to training curriculum and standards. Learned this from feedback participants, initial tools have been developed in process of finalizing supervision. Will we fin information in TSS on how HW are performing? Yes, the tools capture that. ASK TO SEE FILLED IN REPORTS. Shared with management, critical areas of recommendation are shared with EmONC TWG to ensure follow up at national level. Working with CCTs to come up with district mentoring teams for support for weak areas, eg use of partograph.

Provided training models and equipment to 3 Direct Entry Midwifery (DEM) schools. Chipate, **Roan in Lwanshya** and **Inshanga in Chonga?** Baseline needs assessment of all needs for training models and equipment. ACNM flew in to do this, developed tools together with General Nursing Council and principal tutors from schools. Training was done for tutors in the 3 schools, after training, models, supplies and equipment purchased, follow up technical support supervision visit. ASK FOR BASELINE ASSESSMENT REPORT.

Trained 13 nurse tutors and clinical instructors in Skills Lab Management from 3 DEM schools.
TS to 3 DEM schools

Supported development, finalization, and launch of clinical guidelines for use of misoprostol for prevention of PPH launched in Nov 2012. ZISSP has plan to roll out use of misoprostol in some of target districts, starting with 2 districts, in 2 SMGL districts, probably Kalomo and Nyimba.

Other partners are using these guidelines to train districts already.
ZISSP had part of role, pilots carried out by other organizations placed government in position to be ready to adopt development. Z contribution was to support development of the guidelines.

This wasn't on horizon at time contract was developed, rather an imp ortant opportunity that emerged.
Partners are listed in acknowledgments. can interview them if useful.
Partners are very collegial here, even across USAID/CDC barrier. ZISSP provided an external consultant for support of guidelines and supported the workshop where this was developed and agreed on. Also paid for review meetings, finalization meeting, printing of copies.

Key Partners: 2 Ministries, PHO, DHO, UNICEF/UNFPA/WHO (co-funded trainings with them)

ZISSP participated in DFID funded MH review. Large data collection to learn what was going on all over Zambia in terms of program successes, ZISSP provided a lot of background literature for their literature review and also contributed to information about what is happening, maybe also contributed to some presentations for one day conference. Have results of that report influenced any planning or decisions?
Haven't looked at it in detail yet.

One activity left off is support provided for DEM assessment of relevance/performance ??? of certified midwives. Have graduated and been placed in different stations. Observation that cadres were not fitting well into other programs, trained in midwifery but being posted in areas where doing general nursing, so supported an assessment to check on this to report to inform curriculum review. Report will be ready by end of April. FOLLOW UP WITH THIS REQUEST.

MCD has created new newborn care TWG, different from Child Health, Safe Motherhood,

MDRs nationally a weak area. In 4 SMGL district, trying to strengthen this.

MOH collecting monitoring data that indicates whether skilled deliveries are going up or not. Can we get that data at central, provincial, or district level? Can get at provincial and district levels.

Generic question: you do most of the outcomes, eg trainings, expectation is it should make a contribution to impact. Why doesn't %age of deliveries in HF go up after all of these trainings? Zambia not on track for MDG 5.

National statistics on institutional deliveries are static, for program like ZISSP, through structures such as SMAGS do have an increase. But may not impact national statistics, as program we are mandated to show that implementing certain initiatives do contribute but there are many other contributing or confounding factors.

LOOK AT DEGREE TO WHICH DELIVERIES HAVE GONE UP IN TARGET DISTRICTS.

ANECDOTALLY, CENTRAL PROVINCE SHOULD BE ABLE TO TELL TEAM THAT, ALSO EASTERN PROVINCE SHOULD BE ABLE TO DEMONSTRATE THAT.

SMGL did a population based survey, results haven't been disseminated. There will be population data for those 4 ZISSP focus districts. Data collection was timely, was completed by early 2012, but different partners in different districts doing data collection, so sometimes data was different, issues in merging data. CDC was responsible for M&E component. **Data may be shared at next week's meeting**. Will share with evaluation team. CDC sub contracted to central statistics office, developed study protocol and tools through consultative process with partners. getting ethical consent from Atlanta caused delays. TEAM TALK WITH CDC.

May slow down project but increase country ownership, to have more partners involved.

Adolescent Health – Francis Kapapa not here.

Adolescent Health Strategic Plan 2011-2015 launched 11/12
Adolescent Health training manuals for HW
Supported development of national standards for provision of adolescent health services
ADH Communication Strategy (under development)

Key Beneficiaries: MCD, MOH training institutions, communities

Trainings and TOTs, trained peer educators from Mpika and Nakonde RH/HIV prevention. There is criteria on who can participate, still being refined. HC staff choose them.

Do you think with this approach a 16 year old boy with gonorrhea would feel comfortable going to his local HC for treatment? That is the hope. YFC within HC is where adolescents can get treatment help.
YFC should have health care workers assigned to work with adolescents and who have been trained.

Very little or a little? push from gov side in terms of prioritizing adolescent health in country, when go to MCD and talk about it they will mention this. ZISSP has approached adolescent health in small way, focusing on 2 districts in one province, where there is concentration of ?? support, idea is to learn as many lessons as possible and help MCD to scale up in other areas. Do not have strong counterpart on gov side for adolescent health, so ZISSP AH specialist is filling that gap. Discussion to second this person into MCD, he will be going there. idea to strengthen this component within ministry.

If go to districts, don't have adolescent health specialist. The HW we are training for this may be nurse, clinical officers, other responsibilities. Approach has been to train identified people whom we can call national trainers, train the HW, eventually train the PEs and work through existing structures like YFCs in HC. TEAM VISIT YFCS SEE WHAT RESOURCES ARE THERE – PRIVACY, ELECTRICITY FOR DVDS, ETC.

Several peer educators take turns staffing the YFC. Linkages from corner to trained HW. Including and targeting out of school and in school youth equally. High attrition rates in these programs in country experience.

ASK TO SEE ADOLESCENT PEER EDUCATOR MATERIALS THAT THEY USE FOR PEER EDUCATION – don't yet have. Link with National AIDS Council will be at community and district level; they are linked with this through district AIDS task force/groups.

Guidelines were developed with Ministry of Youth and Sports, but not implemented, blueprint has become the adolescent health strategic plan recently launched. Everything starting over for adolescent health.

Key partners: 2 ministries, P/DHOs, Min of Youth and Sports is line ministry working directly with NAC for adolescent health, WHO/UNFPA, Pop Council, chair person for AH TWG is chair at NAC.

Anti AIDS clubs? Many in country. Both school and community based. High community support for some clubs, valued by communities. MEET WITH CLUBS?

Age specific intervention, possible to obtain age distribution on 77 peer educators?

Adolescents 10 to 19, young people 15 to 24 but political definition is up to 35 so peer educators may be older than adolescence.

If HW has reputation of being adolescent friendly, even if a bit older young people will go to them.

Family Planning: Hilda is FP Specialist

CPR 41% 2007. ZISSP goal is to contribute to increasing CPR – strengthen capacity…..FP interventions.

CBD program is quite recent, targeting districts where FP providers have been trained in LTFP methods.
CBDs mean to complement efforts of LTFP – to provide a broad spectrum of methods.

Standard curriculum for CBD training, efforts in 2011/2012, hired consultants last year to finalize.

CBDs work with HFs so get their supplies from HFs. Supplying oral contraceptives and condoms male and female. They are not yet popular or widely used but they are available. Decision made to allow them to do short acting injectables (depo) but scale up of this has reached stale mate some statutory bodies like Health Professionals Council of Zambia weren't comfortable, MCD trying to resolve this. Pilots were one in EP for this, showed that CBDs were able to manage injectables. In training package, because reviewed previously, there is place holder, this is already in training content.

CBDs do they have other roles? Just trained for FP, but may also be SMAGs, or trained as TB supporters, may be multi-tasking. TEAM THINK ABOUT ASKING ABOUT WHETHER IT MAKES SENSE TO BROADEN THEIR ROLE TO SUPPORT MORE INTEGRATED PROGRAMS?

Training data can show what other areas they work in, this is asked.

Mentors were picked from trainers pool, they are for HW not for CBDs. Who supports or supervises the CBDs? This year we will focus more on supervision of CBD, and orient district level supervisors as well as HF supervisors, some HF staff may not be conversant in terms of what the CBD role is. Will develop orientation package, so that staff at both of these levels are oriented to this program.

Which ZISSP seconded staff are involved in CDB training and supervision?
FP at district level is under the MCH Coordinator's umbrella.

They are thinking to reduce #s of CBDs to be trained.

Key Partners include General Nursing Council

3rd ZISSP orientation meeting 11 April

SGML DCs and ACNM trainers will be in Lusaka weekend of April 20th. Make sure hotel has correct check out date, 22 May.

Big group of program mgrs. Present: Emily Monze, MS Team Leader (9 MS); Victoria Mzonga, QI and CC Team Leader (10 doctors, 1 per province, but now have 7, 2 vacancies (WP 3 months, other more than 6 months, first hire didn't' stay long) and 1 new recruitment; Bernard Kassawa, CH Team Leader (9 CHC); Daniel Kwambo, CB Specialist; Benson M&E Team Leader; Julie Nbesha, Grants Mgr; Patrick Mwanza, M&E Mgr, ??? Community and ??? Mgr with Bernard; ?? Mwanza BCC Adviser.

Asking for ZISSP's help with Ministry appointments.

Roman Kendi, Acting Program director for BRITE, Arthur XX, M&E Specialist for BRITE

Management and Leadership Component

MS are in 9 provincial offices,

Key areas:

- Asses and report on assessment of PHO management and technical CB needs
- Develop training and mentoring plan for PHO teams, including M& L training modules
- Develop reports on annual health planning process
- Report on DHMT CB needs assessment
- Develop baseline report son health resource mapping in target districts
- Annual updates o DH resource maps and capacity needs

Major activities: (Get these slides)

- Used MOH performance assessment tools for CB in: planning HRH procurement governance maintenance management and transport, internal audit and financial management
- Desk review of the 2010 PA reports conducted in 8 provinces ASK TO SEE ALL REPORTS?
- Data collected during routine bi annual provincial PAs for 2010
- Short interviews with key provincial staff were held
- Findings guided development of CB plan for provincial and district and hospital health management teams by MS.
- Supported MOH to design training programs in gap areas: health planning, financial management, data management
- Supported MOH in adaptation of marginal budgeting for MBB package to district level requirement and initial training for 2 provinces using adapted MBB document ASK WHETHER MBB PLANNING HAS BEEN IMPLEMENTED?
- Collaborated with BRITE/MOH to develop Management and Leadership Academy (ZMLA) course using a consultative approach with key stakeholders from central, provincial and district level.

NIPA is training institution ASK MANY QUESTIONS ABOUT THIS

DEVELOPMENT OF REPORTS ON ANNUAL HEALTH PLANNING PROCESS: Management Specialist Inception report 20102011 and 2012 planning process reports: address all levels; inform decision makers on existing gaps and areas of focus for following year , 2012 should be available soon.

5. Develop Baseline reports on health resource mapping in target districts: baseline report in 2011, incorporates copy of proposed resource tracking tool;
6. resource mapping activities conducted in 27 target districts alongside the 2012 national health accounts survey (NHA); NHA report not yet ready, currently being drafted by MOH.

Question re development of tool, ZISSP's role, supporting both development and implementation of tool.

Major achievements – Planning:

MOH keeps changing focus, every year something new comes up, so we have to revise materials.

Supported development and revision to 6 MOH planning handbooks for following levels: provincial, district, statutory boards, hospitals, training institutions, HC and community to align these to new MOH planning framework. ASK TO SEE PLANNING HANDBOOKS.

Supported printing and dissemination of all 6 handbooks to relevant levels where they are being used for planning – MOH planning standardized at all levels through the planning tools.

Working closely with MOH side by side to develop the handbooks, not farmed out to consultant. All these handbooks are complete and are in use.

Supported training of 90 planners in approved MOH planning process. These were the ones in place, posted. TRAINED MOSTLY MALES, WHY ARE MOST PLANNERS MALE?

Strengthened pre launch meetings at all levels by assisting MOH and PHO to produce technical planning updates to guide program officers in planning process.

Support provide to MOH to train 43 health workers mostly males from Lusaka and Central provinces in adapted MBB concept. Newly obtained skills used in development of 2013 district action plans. Don't yet have the fully developed plans. HOW CAN TEAM VERIFY USE OF ADAPTED MBB PROCESS?

Still developing the training package.

TEAM NEEDS TO DEVELOP QUESTIONS FOR ZISSP IN THIS AREA. PAUL LEAD THIS?

Supported training of program officers in data quality audits and basic information management. From these trainings the provincial statistical bulletins that provide summaries of PIs in key program areas. They are used as reference documents during planning of health programs. There were attempts in other provinces to do this, the will was there. VERIFY WHETHER THESE STATISTICAL BULLETINS ARE NEW FOR ZAMBIA, thought they were already being done. ON THE WEB THERE IS A USAID SPONSORED 2007 PROVINCIAL STATISTICAL BULLETIN FOR NORTH WESTERN PROVINCE, THESE AREN'T NEW!

MOH has in 2013 adopted aid included development of SB and DQA guidelines in action plans. SUSTAINABILIY.

Implementing DQA for HMIS data indicators. Being headed by MOH M&E unit. SUSTAINABILITY

Performance Assessment:

Supported revisions to MOH PA tools for district, HC and hospitals and aligned them to 2011 to 2015 national health strategic plan goals and objectives. SUSTAINABILITY

ZISSP hired consultant to assist MOH to finalize revision to the PA tools. Monitoring indicators re consistent across different key program areas, revised tools have been adopted by MOH for use in future PA activities starting September.

National Health Accounts (NHA):

TS and FS to MOH and U of Zambia Dept of Economics to train 43 data collector in NHA data collection tools and procedures.

Logistical and TS to MOH - provincial MSs provided technical support to implement 5th round of NHA covering five sub accounts, helped to produce questionnaires.

Hired external consultant on behalf of MOH to assist with NHA data analysis and CB of Zambia NHA team through on site coaching for child health, MH, HIV/AIDS, malaria and TB. Team member supervised the tools development. Report being drafted to inform policy makers on future funding for the five program areas.

NHA looks at health expenditure by different technical areas and funding sources.

Is this done only for national level, or done also by the provinces? Not all provinces were targeted.

Central level has come up with allocation method, this is a national tool but there is also a tool that ministries use to allocate resources to the districts, then districts use those funds to develop their budgets. What are criteria? Population, disease burden, key indicators,

ASK QUESTIONS THAT CLARIFY THE DECISION MAKING PROCESS FOR DISTRICT LEVEL FUNDING.

ZISSP contributed support to development of resource allocation to 2nd and 3rd level hospitals; this formula is being finalized now. Then we will see how formula is applied.

Everyone is planning based on 2007 DHS and then 2012 numbers will come out soon and there will be discrepancies. MCD receives separate funding from MOH; this may create some confusion about how resources get used at district level. LOOK AT THE GUIDEBOOKS FOR DISTRICTS, how much funds should be distributed through HF, how much to first level hospitals, guide is minimum 10% of district budget should go to support community level activities.

For all these processes, ZISSP support has focused on creating a tool to enable powers that be to make right decisions, but program can't influence how much resources go to specific institutions. Our mandate ends with assisting development of tools/systems.

Had gaps with program mgrs. Z supported PMOs to train non financial mgrs. and new ly recruited accountants in approved FM procedures. Sr accountants from gov departments inside and outside health system were used to deliver training, gov approved training materials were used. Training also addressed concerns in area of governance. What curriculum materials were used for this?

Anti corruption and drug enforcement officials came in to do these pieces of training since curriculum doesn't include governance issues, eg anti -corruption.

Related to same problem of poor management of resources, there is a plan that MOH and cooperating partners have put in place. Developed a governance plan a MOU between cooperating partners, Elijah will try to get a copy. **A few donors have begun to fund, others have pledged. MOH had few resources in this time period for districts, between 2009 and 2012**. **Districts received reduced grants and last year reports from service delivery was that many indicators went down. No outreach activities, immunization coverage and other routine services went down drastically.** THIS IS IMPORTANT FOR REPORT TO MENTION AS IMPORTANT PART OF CONTEXT INW HICH ZISSP HAS OPERATED. Way they are implanting, what Emily was saying, working with MOH to develop al these plans but must have donor resources to implement the plans.

ZMLA: developed M&L curriculum to address management gaps in collaboration with BRITE/MOH/NIPA.

6 core module: problem definition, basic principles of supply chain management, project/program management fundamentals, HR management, Finance and Budgeting and Strategic Information.

MOH has adapted ZMLA as approach to be used in MOH CB trainings. WHAT ABOUT MCD?

Medical curricula don't include management training. LOOK AT THE TRAINING MODULES.

HAS BRITE DEVELOPED NEW CURRICULUM OR USED EXISTING CURRICULUM?

Did formative assessment and gap analysis of training needs; looked at other curricula, what was foundation that they adapted from? BRITE has had a generic framework with tools and concepts. BR has a model curriculum that they use in different countries. Originally developed in Botswana in early 2000s to support massive scale up of PEPFAR programs, also adapted in other countries. How

they drew upon existing management curricula; need to speak to a principal from Broad Reach about their training materials and approach.

Is ZISSP trying to address the gender imbalance in terms of people trained? 360 were based on 9 target districts for first wave, supposed to roll out to all 27 districts, plus every province, defined positions that needed this training in 9 plus 9: 20 per (18) districts and provinces = 360.

For life of project: targeting 720, so have 18 remaining districts to train and 20 in each districts. Impact of increased (doubled) DSA.

Have defined positions to be trained, and are training whomever inhabits the positions.

Where gender imbalance problem originates: training institutions are pre service level may not be accepting equal numbers of males and females; there have been attempts at some of these institutions to achieve better gender balance; this is where it starts.

DO WE NEED TO MEET WITH UNIVERSITY OF ZAMBIA Dept. of economics?

BRITE trying to build capacity of NIPA to deliver ZMLA curriculum so that this is sustainable beyond life of ZISSP.

Coordination and Integration with other stakeholders:

ZPCT II Zambia Prevention Care and Treatment Partnerships also working in M and L CB their approach to training. NEED TO INTERVIEW ZPCT II – HARMONIZATION OF APPROACHES IS A MACRO ISSUE TO IDENTIFY AND ADDRESS IN REPORT.

We have agreed that we can help them strengthen skills through our mentorship program. Also when need for more focused follow up training, eg on financial management, they are in 5 provinces, they are in all districts of 5 northern provinces. They have a more academic approach, more grounded in theory. BRITE is relevant to identified gaps, simpler approach. ADDRESS THIS IN COORDINATION SECTION.

Developed a collaboration strategy, being coordinated by MOH. ZISSP tried purposely to leverage different resources, where people are identified with skills gaps by ZMLA, can be referred to ZPCT2 for more intense follow up skills building.

ZISSP collaborated with CDC to implement trainings in DQA for district level POs. ADDRESS COLLABORATIONS WITH OTHER USG FUNDED PARTNERS AND WITH CDC IN COORDINATION SECTION OF REPORT.

Assisted PHO and DMOs to engage local NGOs and CBOs in health planning, implementation and monitoring process. Stakeholder and collaborative meetings. Some documentations that communities were involved in planning process. Where are records?

Assisted health care financing TWG to develop tools for NHA and resource tracking activities. Supposed to meet quarterly.

Questions:

NHA institutionalization – what will that mean?

Current concern is NHA demands a lot of resources to undertake the NHA. This year's 2012 survey, which ventured into 5 sub accounts, very big, then you go to partners not even getting information right, didn't complete the questionnaire, issue was isn't there a way of ensuring that some of the key data apart from that which can only be collected through surveys can continue being collected through a certain system, so that when time to do the NHA survey can focus on specific data that is not already collected. Not all relevant data being collected through HMIS system.

Difficult to collect expenditure data from partners. institutions should be able to document funds received by each donor and how much has been implemented. Want to be able to better capture this level of funding information.

NHA by design is done through surveys. What do we want to do that will change that approach so that it has become institutionalized? Some data has to be collected regularly directly from a funded institution. Shouldn't have to wait 4 years for an NHA to collect that data. Is country using financial part of HMIS? Cannot collect data from employers, from other ministries. Are there some components you can use?

For NSA sub accounts have expanded to five; collection of information for this system has a been a big headache; in past surveys have struggled to get the desired needed data. Unwieldy system. MOH has been trying to find an improved data collections strategy; donors want to share this level of financial data. Gov is saying let's collect this information regularly, eg quarterly. NSA wants to understand the sources and the uses. Donors knows sources, obligations, but also want to know how was the money actually spent. Same is true for gov, they want to know the commitments as well as the expenditures.

On issue of data demand and utilization – so many activities trying to address that. One on HCACs

Issue of provincial statistical bulletins. Was it the design of the project that these activities have to be scattered not done together? Eg, where trainings being done for districts to prioritize their areas. Are you not also building skills for them to prioritize their activities? Works better in other countries.

Re DQA: is there a framework developed to see exactly what ZISSP is contributing?

Current one they are asking for data from previous project HSSP. Luckily ZISSP could provide because it's Abt. 4 years not the ideal interval, just the de facto interval, every 2 years would be better, using more routine mechanisms.

For evaluation, this is a high level question but this is something the gov desires, would be useful to know how NSA is being used now for planning. Is being done nationally, assisting policy makers how to fund the sub accounts. Helping them to understand expenditures in different program areas, composites from different partners, once that picture is developed, helps them to decide how to best available resources. The tool is being used at national level, not the tools being used in the district. Is influencing planning decision at central level. ADD QUESTION ABOUT THIS IN THE MINISTRY AND TH PMO/DMO INTERVIEW TOOLS. WHAT HAS ZISSP DONE TO SUPPORT THE NSA PROCESS at THE NSA TOOL AT PROVINCE AND DISTRICT LEVEL?

The data is now with MOH. MOH is now to generate a report on findings on the NHA survey. That report will assist them to make certain decisions regarding the funding to these sub account.

To distinguish between places where zissp has and hasn't put a lot of resources, NSA is a hangover from HSSP and prior USAID support, was strongly supported under HSSP, not a plan for ZISSP, but MOH decided on a plan that uses a lot of sub accounts, complex, must decide whether investment belongs in MH or child health. ZISSP got pulled in because MOH was partway through process and realized needed external TA and since Abt had done this in past, was asked to help. Wasn't part of ZISSP mandate or something they anticipated doing, but they have gotten credible results. Investing money in doing NSA with poor tools is wasted effort in the country. Previous mandate was to build capacity of MOH planning team that was working to develop the NSA. Including Univ of Zambia, working on this on behalf of Ministry. Challenge that has continued is frequent turnover of staff whose capacity is being built. Many people have moved, CB has proved a big challenge. Maybe going forward we can't guarantee that next NSA will have people with strong skills.

How to institutionalize? Could Univ of Zambia perhaps in future be given a contract for CB to continue this? Since they are already a government partner and have been involved? Institutionalization process can be a focus of a next procurement.

For gov answer lies in building capacity of the MOH team, as well as univ of Zambia. They should both be the focus. this has been the focus of donors who have been trying to support, including our program. our program is rich in expertise in NHA; actually training in quite a lot of countries, challenge in Zambia has been to build a team that would actually stay in both MOH and Univ of Zambia. We also tried to build capacity in Univ of Zambia have since left, don't know if they are coming back.

Main reason for 5 sub accounts, they were linking expenses to achievement of MDGs. Maybe we are over exaggerating what our role is. A couple of short term consultancies is not a big deal. Even if there was an institution here doing the nitty gritty work, might still need a consultant now and then to design tools, do trainings, etc. In this case a 47 page instrument was already designed and circulated before they asked for TS.

TEAM NEEDS TO LOOK AT THE RESULTS FRAMEWORK AND COMPARE INTERVIEW TOOLS WITH IT.!

NEED TO LOOK AT MATRIX OF GROUPS TO INTERVIEW AND COMPARE INTERVIEW TOOLS WITH THAT.

Is Zambia Management and Leadership Academy a localized institution or a training program? training program.

Are MS doing other kinds of financial support activities? Is so, what?

Program is co funded by Merck Foundation. Deal that was brokered between USAID and Merck Foundation. Merck believes you can invest as much as you want in specific aspects of health but unless you have good leadership and management it won't grow, had idea of funding in one country to show what management and leadership could do. Point of collaboration is at BRITE; they give money to BRITE. For same project. BRITE manages which share of costs are attributed to Merck and which to ZISSP, and they bill both. Only for ZISSP districts. Speaks to why foundation of curriculum is what it is; BRITE is entity that Merck had already selected for this training program; they were not originally a ZISSP partners, USAID brokered this partnership.

Z didn't go shopping for best curriculum; Merck had already done that and chose BRITE and USAID said wanted to attract the Merck (leveraged resources) to Zambia.

How often are DQAs conducted, who comprises the team, where can we get a report?

Provincial teams go to the districts. So CDC team and Provincial Sr.Health Information Officers have been spearheading this and ZISSP has provided financial support to do trainings and the visits to sit and look at data. We should be able to get recent reports. Supposed to be done quarterly.

Where would records be? Should be at both P and D levels. TEAMS ASK FOR COPIES OF DQA AT BOTH PROVINCIAL AND DISTRICTS LEVELS. ADD TO BOTTOM OF INTERVIEW TOOL? WOULD BE MORE USEFUL AT DISTRICT LEVEL.

THIS YEAR our plan is follow up these trainings.

DQA started in 2012 with ZISSP, wasn't happening before, part of the realization that you can't plan without good data. Initiative was from MOH, not from donor.

Had a gap analysis, saw weaknesses, refer to gap analysis November 2010.

MOH wants to develop a guideline in DQA so there is a uniform way of conducting data activity. CDC will be part of this. MOH has already started more discussions on this, **if you are around, sit in on meeting**. Picked up some common language. FOLLOW UP WITH Z ON MEETING DATE AND TIME?

Activities that we are referring to were started by the MOH, started with PMTCT, going there quarterly to check on data. No system or formal methodology. We need to be careful to check whether each technical program checks on relevant data, or is it all coordinated into one package? This was started not by PEPFAR but by M&E unit.

Does need to be standardized.

Clinical Care Specialists

Currently have 7 positions filled, having turnover. Working at all levels in 9 provinces, now no one seconded I n10th provinces, but that is being covered by one of the CCSs.

QI:

QI committees to enhance quality of health service delivery. identify health service performance gaps from HMIS, PA, performance review meetings; conduct root cause analysis; identify interventions; monitor and evaluate performance

TA provided during annual provincial and district planning to identify areas of priority for next planning cycle based on local health indicators.

PA conducted bi annually to DHOs and HFs to identify health performance gaps (standard tools for all levels with selected health indicators for all health programs)

TSS is a follow up to PA to address identified gaps and can take several forms, including clinical mentorship.

This is done even at health post level, but not all facilitate are covered in a given period. Maybe only 2 weeks in which to conduct PAs, first have to assess district office, then hospitals, then will go to some but not all health centers/health posts. Next time they will visit others, but sounds like many may not get assessed.

Component of community within tool, but process does not include community member participation or feedback. But in some places they may be invited.

Development is underway for a mechanism for communities to assess their HCs, greater focus on QI, need to have HFs accountable. LOOK AT WHETHER TO RECOMMEND SUPPORT FOR DEVELOPMENT OF THIS COMMUNITY COMPONENT OF PA, AND HARMONIZATION WITHIN EXISTING PERFORMANCE ASSESSSMENTS.

Quick background: during days of Central Board of Health there was an advisory body powerful could hire and fire, now what is happening is they are working their way back toward greater community participation, but doing so cautiously because they don't want to get back to where they were before. There was a time when communities were deeply involved and had power, and depending on community they continued to work and fell apart.

Households are being assessed on all health areas, from environmental to disease patterns, information collected by CHAS. TEAM LOOK AT HOW ALL THESE PIECES DO OR DON'T GET HARMONIZED, COULD BE BETTER HARMONIZED.

Health program performance reviews to assess performance gaps according to set standards and identify solutions. Quarterly provincial activity with DH program officers. Evaluates selected health program indicators from each district, identify performance gaps, achievements, share best practices, challenges, identify areas for TSS and mentorship in all programs.

MOH has selected key indicators. Outcome indicators. Get the list to put in the work plan. Get the HMIS indicators.

TA during annual provincial and district planning: to identify areas of focus for coming year based on evidence, performance issues at level provincial and district and HF level; TA to enhance use of HMIS at each level; ensure identification of cost effective health interventions; CCS facilitate the view of clinical areas in work plans from districts and HFs.

Provincial or District integrated meetings – the MSs and CCSs collaborate for these meetings. Looking at financial component and HR components and health indicators. ASK QUESTIONS ABOUT WHAT THIS INTEGRATED PLANNING ACTUALLY LOOKS LIKE.

Clinical care mentorship to improve health worker performance.

A mentorship package was supported by previous project but not supported to ART program, so need for mentorship in clinical areas not only for ART, also other support areas related to clinical care.

Formation of multi disciplinary CCTs at P and D levels: identify people strong in components: pharmacists, lab personnel, nutrition, nurses. ZISSP supports them to hold meetings.

CCTs review HMIS, PA, performance review reports to identify mentorship needs and assign appropriate mentors to a particular HF or HW. That may come from provincial level. How ascertaining that qualification of mentors are up to date and up to speed?

ADD QUESTIONS ABOUT THIS TO HEALTH FACILITY CHECKLIST. MAKE IT A TOOL FOR THIS TEAM.

Where can evaluation team find mentor team members? ZISSP has developed CCT guidelines.

CCTs facilitate the maternal death review. MDR committees are found at each district, chaired by DMO, some members may also be part of CCT who have to follow up that case and fill out the forms. Done at district, HC, community level. ADD QUESTION TO DMO INTERVIEW AND HEALTH FACILITY CHECKLIST: DO YOU PERFORM MATERNAL DEATH REVIEWS AT THIS HEALTH FACILTY? If so, WHO INITATIATES, WHO CONDUCTS? WHERE ARE REVIEW FORMS SUBMITTED?

Have you had any maternal deaths in the past ??. If yes, was a MDR conducted? If yes, who conducted it and where was data submitted? Look for this at district level not facility level.

If answer is no, ask if you have a procedure in place for MDRs.

DMO will be notified, will call committee who will conduct the review. SMAGS will inform HC if there is a community death, and HC will inform DMO.

In terms of actual MDR, this is more focused on those deaths that occur at hospital and HF level.

The form also asks for deaths in the catchment area; this is part of SOW for SMAGs.

CCTs facilitate clinical meeting and health symposia as a QI strategy, topics are based on identified gaps in health service delivery, and also used as a forum to share updated guidelines and information from MOH.

Where find QI trainers? At provincial level. They have trained 515 HW, will train more this year.

Facilitating formation of QI committees in 5 provinces: TEAM MEET WITH QI COMMITTEES? Could set that up through CCS at provinces. Do committees have a scope of work?

Is there 100% overlap between CCT and QI committee? Yes a lot, because limited #of people from which to choose. The TORs for CCTs and QI committees are different. Clinical mentoring is one of several strategies for QI.

Are mission and other private sector hospitals included in assessments? CHAZ institutions are under the district management.

Gov is specific about inclusiveness of all stakeholders at Provincial level QI for QI committees.

HF supported by CHAZ are integral part of national health care system, receive funding from MOH.

Under Clinical Mentorship

Facilitated review of CCM operational guidelines and training curriculum

Development of mentoring tools for different health disciplines, generic

Facilitated national launch of reviewed QI training package

Facilitated formation of CCTs: 6 provincial CCTs and over 38 district CCTs in 6 provinces.

Trained 24 provincial mentor trainers and 641 multi disciplinary mentors

In past year Mentored: 3,024 HW through 4,012 mentoring sessions.

Previews: supported 13 quarterly performance review meetings since 2011

422 CLINICAL MEETINGS/SYMPOSIA HAVE BEEN CONDUCTED 422 –provide continuous staff development strategy

Coordination and Integration

Collaboration with CDC through MOH to develop QI guidelines and review training package, also AIDS Relief and ZPCT2 were involved, also with CDC to train health workers from SMGL districts EP in QI with TA from HealthQUAL International. What is in that training package? ADD QUESTION ABOUT THIS FOR

INTERVIEW CIDRZ IN NYIMA AND IN MANZA WOULD BE JHPIEGO for training on clinical management.

MOH Perception of ZISSP Support

Evidence of ownership in several ways: get the slide.

LOOK AT WHERE MOH HAS CO FUNDED ANY ACTIVITIES AS EVIDENCE OF PROGRESS TOWARD SUSTAINABILITY. This QI area looks has evidence of good progress toward sustainability.

Success story mentioned orientation in basic anesthesia – who is doing that training? Also pulling in other training resources to work with CCTs, eg for basic anesthesia.

Grants Program: One of the 4 main areas of the community component.

Other community components are Community Health Planning, scaling up of SMAG and health promotion program (BCC).

For CBOs and FBOs that are implementing health communication and service delivery interventions.

Criteria: can be found in AR.

Demonstrated capacity in health promotion, BCC, health services in 5 areas, adolescent health.

Appraised by Grant Support Teams (GSTs) t district, provincial and national levels. GST members include MOH, ZISSP, Provincial and District Health office staff.

USAID through COTRO approves, total 3.6 US million to be disbursed in 3 cycles. Org can receive 40 to 100,000 and have up to 12 months to implement their activities

11 grant recipients awarded for first cycle of disbursement amounting to USD 975,529.05.

ZISSP mapped potential recipients with MOH, PHO, DHO as well as gap in information and services.

Developed annual program statement for Grants Program and planned grant making process based on mapping.

Developed guidance documents: manual, analysis plan to identify grantee, orientation package for GSTs, annual program statement, training manual, organization CB training manual, BCC framework.

Target populations: women and men of child bearing age; under 5 children; adolescents; PLHIV; traditional leaders.

Didn't look for equity across 5 health technical areas, looked at the criteria and qualifications above.

Have developed MOH/USAID approved (and owned?) systems for grants program.

Grantees are community level trainings in: SMAG, community health planning, malaria rapid diagnostic testing, adolescent RH and PE, HIV/AIDS ART adherence counselors.

Grantees:

Keepers Zambia Foundation, health planning MH

Childfund Zambia MCH Nyimba

CIDRZ, community response to primary health care, Luangwa

Sinazongwe WV ADP malaria, maternal and newborn health, FP, CH and Nutrition and HIV/AIDS

Thandizana CB HIV/AIDS prevention and care MH Lundazi SMAG

Serenje Pastor Fellowship FP, SM HIV, community participation – Serenje District

NZP+ Mwinilunga District, support groups

Kalomo Mumuni Center access to maternal, neonatal and CH

Diocese of Mpila HBC P reduction of malaria diagnostic testing

Groups Focused Consultation community participation in health planning Manza District, Luapula Province

Community Integrated HE Program (COIHEP0, Lwanshya District, increasing health seeking for HV/AIDS

Grant delays: before disbursement, APS and grants manual had to be approved by USAID before could disburse funds. Process included vetting at community, district, provincial levels.

Participatory process. Application deadline was Feb 2012. First awards were approved July, but disbursed September. About 7 months ago.

USAID approval process was faster than grants review process.

For 2nd round not going to go through this solicitation process, going to pick from what was recommended by MOH in first round. There was a scoring process, look at grants manual and

orientation package, scoring included desk appraisal and field appraisal, when made recommendations to national GST, they did another round of scoring.

What capacity assessment undertaken as part of the grantee application and selection process?

Review guidelines for this information.

Initially targeted only ??? districts. When Ds and Ps were selected, asked them to prioritize recommendations based on district gaps.

Having committee helps to address issue of favoritism. Committee and clear rating process.

Also had 3 levels of validation – D, P, N. good checks and balances.

What about the other 169 applications? Desk appraisal was screening process. Rejected those that didn't meet minimum criteria. Also had a bidders meeting, so had records of all organizations that showed interest at bidders meeting.

GSTs not only select grant applications for funding but also provide TSS to grantees – what does that include? Established monitoring and support system. What does that include?

Funded on a monthly basis; expected to send monthly financial and program reports. Training manuals were for grantees, trained in grants management including FM and reporting. Sub contracted an organization to provide this training, received reports, going to change this methodology for next cycle.

Which documents are grantees supposed to have? Org CB training manual for grantees, next step is to train them in the BCC Framework.

How to look at effectiveness/impact at community level – gov doesn't have good systems for capturing impact at community level; in terms of grantees meeting their mandates, in initial proposal have objectives and indicators, can see if they were met.

How to look at accomplishments within the BCC framework?

These grants are meant to complement the other work ZISSP is doing at community level: eg, # of trainings for ZISSP, so these activities fit into the larger targets for this, making sure they are using the MOH standard curriculum, eg for ICCM, or for IYCF, ZISSP as part of monitoring makes sure they are using the curricula correctly.

TEAM NEEDS TO MEET WITH THE GSTs.

The CHCs work in collaboration with the GSTs to monitor the activities and ensure QA especially for trainings.

Initially saw some cash requests saw areas where organizations weren't planning according to ZISSP standards. Eg, trainings that were too few days. So a dialogue to ensure alignment. Benefits the organizations in that they are better connected to the national framework.

Already ZISSP is thinking that need to invest in more resources for CB for grant organizations themselves in addition to just giving them financial resources.

M&E was indicated as a blank in capacity; training alerted CBOs to what they needed to be able to do.

In terms of outcomes: already alluded to linkage with SMAGs. Big targets. Tomorrow will talk about other community activity targets. How does this fit into the larger community strategy?

Believe their monitoring and support system is working well; when they note gaps they don't disburse funding until it is cleared up.

Monthly disbursements, monthly reports. Grants being awarded under a contract. Funds aren't dispersed until others are liquidated. This is Abt's procedure for handling grants under contract agreement. Also have internal delays for disbursing grants monthly.

On time reporting rate to date? About 50%. NEED TO DEVELOP QUESTIONS FOR GRANTEE ORGANIZATIONS. Grantees can't implement all their activities according to plan due to delays.

Delays are at various levels, in spite of CB efforts up front, eg on how to write report, sometimes monthly reports are incomplete or not done according to guidelines, causes delay.

here is a project winding up now called Local Partner CB Program, good project, trying to figure out how to do successful small grant making.

4th meeting with ZISSP Friday 12 April: Community Health

Community Health Planning:

Community health resources mapping conducted in 2011 to guide planning of community interventions.

Held workshop with MOH, PHOs, DHOs and communities to develop strategy for community activities based on results.

Community Health Planning – ZISSP facilitated revision of handbook to guide process of engaging communities. Also provided training to HCACs and NHCs to foster activities participation in community health planning. ASK ABOUT THIS DURING FOLLOW UP TRAINING CONVERSATION.

Roll out of SMAG program: platform for communities to address FP, pregnancy and newborn health. Main role of members is to provide information and make referrals.

Partners: ministries, pregnant women and newborns: NHCs mobilize community to access health services, HCACs provide link between health care systems and communities, SMAGs mobilize communities to respond to issue related to safe motherhood; traditional and other leaders provide leadership for effective community engagement.

Achievements: Trained 1,253 HCAC and NHC members in community health planning; printed and distributed revised Community health Planning Handbooks for use during 2012 planning cycle.

Expansion and formation of SMAGs in 10 of 27 ZISSP target districts, working with ACNM. Trained 115 SMAG trainers, now have master trainers in the 9 provinces and have at least 8 district trainers for each of the 9 provinces, and 1,046 SMAG members against life of project target of 3,000 for 53 of 135 target rural HFs Sustainability step. Also have some in the 10th province, in Machinga.

We are talking about male involvement in area of safe motherhood. Males have historically been a stumbling block, so male involvement in SMAGs is notable change. WHY ARE MEN WILLING/INTERESTED TO JOIN SMAGS?

Also have developed monitoring tools for SMAGs, data management tools being used to monitor and evaluate SMAGs program. ASK TO SEE THESE TOOLS DURING FIELD VISITS. adaptation of ACNM HBLSS training curriculum is nearing acceptance as a Zambian training manual (did ZISSP have key influence for this or was it eg a TWG activity?) adapting it and calling it the SMAGS Training Curriculum, using not all modules (see previous notes). ADD TO TRAINING QUESTIONS. MCD eager to have a standardized Zambian training curriculum for the SMAGs. Have other players who are training the SMAGs using other curricula; this will harmonize the national approach. USEFUL INFORMATION FOR COORDINATION AND INTEGRATION EVALUATION QUESTION.

Provided incentives to SMAG members: to most members trained, 850 of 1,040, materials including bicycles, uniforms, megaphones, umbrellas, raincoats, other items. First time when community members have received so many materials.

ZISSP contribution to CHA program:

MOH recruitment process for CHA –

Sample: 165 communities in 48 districts in 7 provinces, 2 CHAs nominated per community.

Recruitment: advert, application, short list, interview, nomination, final selection, intake; person should have attained grade 12.

2011-2012: in collaboration with MOH visited schools on monthly basis to hold meetings with school management to assess progress and come up with solutions; facilitated development of academic and administrative regulations; facilitated affiliation of training school to U of Zambia School of medicine (Examination Council of Health Sciences); led process of review of pilot curriculum before commencement of 2nd cohort of students, in Sept to Dec last year. Facilitated development of curriculum for CHA training supervisors 9 health centre in charges) and subsequent training in seven provinces. THIS WAS A MAJOR CONTRIBUTION LAST YEAR. Facilitated training of 207 CHA supervisors, paid 10 tutors salaries and benefits.

2013: led orientation and formation of gender club in CHA school with participation of all 292 students, to enable students to take gender aspect to community level. ASK WHAT THE GENDER CLUBS DO.

ZISS will pay 10 tutors salaries up to March 2013.

ZISSP has been mandate as Focal Point organization to coordinate the SMAGS program at national level. Meet Cecilia Tembo in Luangwa? Success story.

When communities are well oriented and empowered, capable of effectively advocating for their health needs. VALIDATE THIS IN FGDS.

Challenges:

Retention and motivation of SMAGS members; unable to provide support materials to all members.

Irregular TSS to community volunteers by HF, shortage of trained staff at HCs.

Inadequate gov funding to support community level activities. Most community level activities are supported by donors, so sustainability questionable.

Suggested Improvements: develop guide to assist 2 ministries in community health planning. Zissp have drafted such a guide, then orient DHS and HC staff to simplified guide.

Questions:

By end of project how will you measure contribution to HR program through support to CHAs?

CHA program came along the way, not part of original ZISSP plan. Came out of recent community health strategy approved by MOH, one component was introduction of CHA school in Ndola. When this was introduced, Ministry asked for assistance, how ZISSP got involved, for training of 10 tutors, training of supervisors, financial support came from PEPFAR partner implementation framework, bilateral agreement between USG and Gov of Zambia to provide supplemental funding to strengthen specific gov programs using PEPFAR funds, one program was the CHA program. An unexpected mandate, looked for mechanism to funnel funds and ZISSP chosen.

In typical training function, one way of measuring success is on output. We can say that we have contributed to graduation of 307? students. When this started in June 2011 ZISSP already involved, found certain things in curriculum that we started to help improve, found there was no examiner for program, went in and looked for an examiner, organized the affiliation with U of Zambia. Had 100% pass rate in first cohort. IS THIS IN THE ZISSP M&E PLAN?

During pilot, it was 47 districts in the sample.

Is there a master list of SMAGs, ensure no duplication of efforts. ZISSP knows which partner is working with SMAGS in which districts and which partners have provided which incentives. That was done at level of MOH, realizing the need at community level is really vast. If you look at all SMAGS attached at the various HCs, have had partners working in areas for many years without saturating communities, so ZISSP started with the mapping exercise to find out which HFs that were not yet taken up by partners.

MAYBE COULD MET UP WITH SMAGS supported by other partners.

Gender club: have you incorporated gender as training topic for any community activities? Yes in CHA curriculum. For SMAGs? Inserted in revised curriculum for CHAs, 2nd cohort will receive a strong component of gender. Re SMAG training, ASK FOR TRAINING MATERIALS FOR CHAS AND SMAGS.

If at community level males are going to be seen talking about RH issues strongly, community now looking at these issues as not just women's issues. Some topics that are covered in SMAG training, and HBLSS approach, there are community meetings, and discuss what men should be able to do in areas that affect women's health: pregnancy, childbirth, newborn health.

Training can help volunteers to confidently discuss gender issues at community and household levels; this can be a training skill included in the training. Per ZISSP, it is.

For SMAG volunteer criteria, we have aimed for 50/50 gender approach. We pick SMAG members, we pick them from existing structures, so can include community health workers, TBAs, traditional village headmen or leaders. In most cases they are men. Other community volunteer structures, eg PMTCT counselors. Or health promotion people. We look at how communities are zoned, try to ensure that both males and females are coming from each area. In some cases can only find females, in some cases only males, but overall aiming for gender balance.

ADD QUESTION TO FGD ABOUT HOW WOMEN VOLUNTEERS FEEL ABOUT MEN VOLUNTER AND HOW COMMUNITY MEMBESR FEEL ABOUT MALE VOLUNTEER.

Every month groups bring SMAG reports to HC. Have indicators for work they are doing in community, using pictorial indicators. Able to see through registers how many people reached by SMAGS, THIS IS A ZISSP brainchild working with ACNM. One thing that was missing was removal of data from primary source - eg, if you have 7 zones you have 7 registers coming to HF, so needed a data aggregation form, so can see all data in one form. This is how SMAGs are managing. One thing we quickly note is increase in institutional deliveries. How many are a result of direct referral? Has project collected data from HF, ASK TO SEE THIS DATA. Nyimba would be good to see this data.

DO ANY PICTORAL INDICATORS REFLECT INCREASED IN MALE INVOLVEMENT IN MATERNAL HEALTH?

HOW CAN CHANGES IN MALE ATTITUDES AND MALE INVOLVEMENT AT HOUSEHOLD AS A RESULT OF SMAG ACTIVITIES BE MEASURED?

Before actual training, we conduct a pre assessment exercise, to get baseline FORR WHAT DATA?

There is a lot of pressure on skeleton staff and their workloads have increased as a result of SMAG activity?

DHOs are expected to maintain bicycles. ZISSP is supporting DHOs to do what they would have done with sufficient financial resources.

About how much time should a SMAG volunteer spend being a volunteer? What is time commitment? AT LEAST 1 to 2 hours meeting maybe twice a week. Not just meetings, sensitization, but also escort pregnant women to HF, also visit newborns. ASK RE FOCUS ON PNC IN SMAGS AND CHA TRAININGS AND WORK. ADD QUESTION SPECIFICALLY ON PNC IN BOTH FGD QUESTIONNAIRES IF NOT ALREADY THERE. KEY EMPHASIS for SMAG volunteers is community sensitization meetings. One topic per meeting.

Part of JD is to do household visits, they are documented.

Re CHAs, 20 of ZISSP districts are involved in this program. They are scattered, based at health posts.

Gender distribution of Grade 12 graduates? 51 male/49 females for CHA cohort, selected from rural areas.

In Lundazi, can find SMAGs trained by AfriCare. Manza, PLAN, UNICEF, UNFPA.

Aiming for 60% community coverage for SMAG groups. (??)

Financial support for CHAtutor salaries ended last month –what happens now? There was a promise from GRZ to take over these salaries. CHECK ON THIS.

What changes do you want to make in male involvement in RH? Want men to put money aside during pregnancies. First change mind set of male volunteers. Taking part in FP. Help during emergencies. Qualitative research for SMGL cites men as barrier to women seeking ANC. If women are seeking ANC earlier and having FANC visits, suggests men are changing. May have other secondary data that is suggestive of change. We do start seeing increased in ANC visits, men escorting their wives.

SMAG data is not in general register. Some data might not be in the registers. LOOK AT REGISTERS AND THINK ABOUT HOW OTHER DATA COULD BE DOCUMENTED. During development of tools, have had discussions on how many data parameters can we include. GET DATA COLLECTION TOOLS FOR SMAGS.

The report has an annex; and data aggregation forms are there.

Refer to Report from ACNM. Jean has.

Also will show us what tools we should look for in field.

BCC Program

Structures and processes to plan BCC activities, increasing community involvement.

BCC Framework: reviewed existing communication strategies at national level (HIV, SMotherhood, there was no FP strategy).

Assessment done in 3 provinces, 6 districts, looking at BCC materials, activities, coordination, planning, harmonization and synergy of efforts.

BCC Framework interventions:

CB for D health promotions focal persons; ToT to facilitate formation of IEC/BCC committees at D level, CB and training tools for drama, master trainers for community drama, CB of community drama groups

DOES FRAMEWORK INDICATE KEY DESIRED BEHAVIOR CHANGES AND HOW THEY WILL BE MEASURED AND IN WHAT TIME FRAME?

RDL Program for SMAGS ADD QUESTION ABOUT THIS TO SMAG FGD TOOL.

Started in 2011. Used to supplement MOH training, provides refresher education. Not really a BCC activity, a CB activity.

Does this not also reach community members beyond SMAG volunteers? So used as IEC mechanism?

Have produced radio program in English, 6 programs, also being translated into 5 more languages.

Follow up activity is formation of listening groups; once program starts airing, LG will consist of 10 members, 2 are already trained SMAG volunteers, will have discussion guide to serve as teaching tool So serve 2 purposes: educate groups and reinforce SMAG training?

Is this different from behavior change, more IEC and CB blended, although educational messages may promote change. ASK TO SEE LG DISCUSSION GUIDES IF DEVELOPED. ADD THIS TO TRAINING QUESTIONS.

Creative brief – document used to share with production houses and stakeholders to strategize and develop materials, gives direction.

Major Achievements

Developed BCC Framework

Trained Sr Health Education Officers at P and D levels in 9 provinces and 72 districts to build leadership skills for BCC programming. MEET WITH HEALTH PROMOTION FOCAL PERSONS DURING FIELD VISITS.

Helped districts to form IEC/BCC tehnical committees to strengthen BCC programs, coordination, implementation in 27 target districts.

RDL program: Have developed a flip chart for use with home visits and community meetings. Pictorial but also narrative key messages and matches radio program content. Two posters, one on male involvement, one for women during pregnancy. Will also provide discussion guides, bags.

Drama Capacity: CB for drama groups to write scripts and focus on desired health outcomes, behaviors, barriers to communication. Trained 36 D Master Trainers to further scale up drama CB at community level. Total 804 in drama BCC.

Success story emphasizes harmonization and coordination, involvement of DCO, traditional leaders, churches and district education board in sensitization and mobilization for 2012 measles campaign.

Partners: MOH, NMCC, MCD, Communication Support for health

Role of CSH: develops national level interventions, training, but ZISSP provides framework for translation and localizing these strategies at local level.

Integration of BCC activities into MOH annual planning cycle with separate budget line enables commitment of resources for preventive and promotion activities at district and community levels. ASK FOR EXAMPLES.

BCC efforts to promote demand for health services can stress HF that are already overloaded or understaffed. ALWAYS A RISK WITH COMMUNITY LEVEL HEALTH PROMOTION ACTIVITIES.

Plans to have in line survey to look at program results.

What kind of behaviors might you measure? Earlier ANC care. DO MESSAGES COVER ALL 5 TEHCNIAL AREAS? Bcc Framework includes messages. Look in Framework under key essential health actions.

Stakeholders can localize messages.

Was any baseline done? Not for BCC Framework. The endline is for the RDL program.

For drama, will develop tools that will help us look at validity and fidelity of activities.

These and other activities are influencing community demand at local level; how can you attribute the radio programs and drama interventions to overall change?

Wanted to do baseline, costly. For RDL want to have a pre assessment, will essentially do a pre and post knowledge assessment for each program. There are intervention and control districts. Will be airing in Kalomo, Manza, Nyimba, Mamba, Kalalonga?, Luanshya.

Will use existing community registration.

Last year did CB of community registrations prior to airing programs.

Communities prefer local radio stations, know the voices, ZNBC has wider national coverage but doesn't' reach all communities.

RDL is what ZISSP has brought as an innovation, this will target the already trained SMASg, first they are trained in normal curriculum, but it is Z's initiative to complement existing skills and knowledge.

Want to show the additional effect of this innovation. Will have certain SMAG groups that also get the RDL activity others will not.

Will look to see if this additional activity makes a big difference in outcomes. We want to bring innovative practices.

Radio programs intended to open dialogue with community members who have heard the programs. Operational research.

LISTEN TO RADIO PROGRAM.

MOH realizes importance of strengthening interventions at community level, has been on board with this planning. Di of PH and Research has emphasized the need to be strong with BCC.

INTERVIEW DIRECTOR OF PUBLIC HEALTH AND RESEARCH?

We keep mentioning community structures, NHCs and HCACs, they were there at time of Central Board of Health. Do we have systems in place through MOH in terms of how often they should appoint these committees and who should sit on them? In past there was a mandate to make sure they existed and who should comprise them.

MOH strategy puts CHA in loose position in related to committee structures.

If you go to District, there is a recognized body a District Advisory Committee, then at HC there is a HCAC, NHC have never been abolished, things went silent, these are structures that worked well in past, current system still recognizes them, trying to revamp. MEET WITH DAC DURING FIELD VISITS?

In your community health strategy, how are you addressing the NHC? What is their role? They do play an official role.

If you look at reporting structure, CHA reports directly to parent HC. No documentation that CHAs hould attend HCAC meetings, even though this person is collecting all community data but not member of NHC or HCAC, so there is a coordination gap.

CHA is guided by a national strategy that should look at coordination of all resources.

If you look at strategies that exist, these existing strategies are older. As system matures, maybe this can be addressed during revisions.

This has been identified. Even CHAS find themselves not connected.

NHCs are part of that volunteer structure and in most districts or HFs you find high attrition rates.

We have a document on community mapping of existing structures. On the black jump drive.

Currently with community planning handbook development, also looked at ways to strengthen these structures where in place but not performing well. came up with division of roles and responsibilities.

As talking with communities about community planning, have also discussed these roles and recommended representation on NHCs and HCACs. MOH has embarked on this process. Has to be ongoing due to attrition. Even if NHC performing well now, may not be in future.

Currently team working districts is doing this as part of community health planning support. Who is district focal person to keep this going? There are FPs for this.

With movement to MCD, other activities are already taking place at community level. Health promotion activities have brought new dimensions. What if MCD requests ZISSP to harmonize these various activities at community level, eg OVC? Know MCD moving toward coming up with one reporting system for community activities, that structure is built around existing structures.

THIS IS A MACRO QUESTION THAT WE CAN ADDRESS IN REPORT.

1.5 years ago USAID floated a project called ?? strengthening local levels, has never come out since Ministry started to split. Where are these resources? ZISSP may become the vehicle to channel those funds. Who does M envision as the sustainable community FP for reinforcing community structures?

Which ones have you done together with CSH and has there been cost sharing between two projects?

Malaria interventions and training:

Behavior Centered Programing Approach was done by CHS, ZISSP helped to develop curriculum and do a national TOT, but ZISSP CHCS did district level training. ADD THIS TO TRAINING QUESTIONS.

CHS leads USG partner stakeholder meetings, ZISSP is there. Cost share the national IEC TWG with CSH. CSH participated in development of BCC Framework and design of radio program document….for first year thought we were seconding staff to them, so much collaboration on communication strategies. BCC Framework easier for ZISSP to work on as a result of this earlier collaboration.

This Zambia's first health promotion guidelines: with WHO, other partners led by MOH.

BCC, RDL, drama only, IPPT with co investigator, purely supported by ZISSP. All activities discussed today were ZISSP led and supported, with partner collaboration.

BCC – any formative research? Theory of change?

Yes formative research with IPPT. But for BCC framework, desk review and other research that had been done. Did use former project HCP, looked at those former studies and strategies developed in Zambia, and DHS study. Was this information in your documents?

CSH also did formative research for national campaigns, which are foundation on which BCC Framework was laid. We have worked with CSH closely and utilized their studies in development of BCC Framework.

In Manza, Plan and JICA also want to establish listening groups. other stakeholders can buy into program, even if ZISSP not paying for air time, other stakeholders may do.

DHO can also buy air time on community radio.

Launching the RDL program May 31st and program starts running that weekend. Translation is finished for language to air first week of June (4 languages) – scripts are done in remaining 2, but haven't yet done the actual production of programs. Districts have committed to buying batteries for radios. Have also used CDS on memory sticks in some areas.

Where are Sr. Health Education Officers/Health Promotion Officers. PROVINCIAL LEVEL; INTERVIEW THEM.

What we have done beyond ZISSP districts is training ..zoned the country, E and S and L, CB NW and C together, Mu Lu N together. Did training in all 9 provinces, but not in all districts.

104 trainers includes drama, community radio stations, BCC Framework training and SMAGs, more males than females. At radio stations and in drama groups you find more males.

Any discussions on changing criteria or approach so more women can be empowered to participate?

In high school girls are part of drama groups, but when get married don't see themselves as having a role in drama groups. Women are there, but there are more men. LOOK FOR DRAMA GROUPS IN FIELD VISITS. Luanshya. Will share a list, they are also on training details.

Collaborative relationship with NMCC for BCC?

There is a health promotions officer at NMCC, also work with Research Principal. INTERVIEW THESE TWO GOVERNMENT AS WELL AS ZISSP SECONDED STAFF AT NMCC.

Child Health and Nutrition

Under five mortality rate reduced from 168 in 2002 to 119 per 1000 LB per 2007 DHS. IM rate from 95 to 70 per 1000 LB. Still these rates are among highest in world and sub region.

Zissp goal: contribute to reducing childhood morbidity and mortality by CB for MOH MCD to coordinate, plan, implement and monitor health programs.

Looking at more focus on diarrhea and pneumonia (?)

Train HW in IMCI: CB of HW in IMCI so that at least one person at HF level is trained to manage sick children: ADD QUESTION TO PMO/DMO INTERVIEW OR HF CHECKLIST TO ASSESS THIS.

IMCI Strategic Plan - REQUEST COPY IF DON'T ALREADY HAVE. Includes focus on empowering mothers to seek health care for sick children.

Enhance Performance Assessment and TSS – 6 to 8 post training follow up visits – how well utilizing skills, how well incorporating ICMI at HF level, challenges in adapting ICMI services. Have integrated follow up support into existing PA and SS visits. linkages with ZISSP supported CCAC teams to support for sustainability of acquired skills.

Extend RED and other innovative strategies: CB for HW and community volunteers through training and mentorship to improve access to and utilization of services. Has helped to empower community volunteers to participate bot in planning and mobilization and default registering for immunization and other child health services. ASK ABOUT THIS IN FGDS.

Strengthen community child health registers and monitoring tools. Need to know what are weak areas to be strengthened. Did an analysis to identify key weak areas, community child health registers. ASK TO SEE REGISTERS AT HF VISITS.

Strengthen nutrition interventions and linkages at all levels: Strengthen integrated community level guidelines and training manuals; increase pool of national/provincial/district trainers through TOTs in IYCF; build capacity for health workers through training and mentorship in IYCF; build capacity for community volunteers in IYCD as well as HIV and nutrition.

Have looked at 3 districts in NP Luapula, XX XX, other partners with nutrition interventions. Selected Chienge no other partners there. Lufanyama and Masaiti including Luanshwa have received this CB, in SP Siinazongwe and inWP XX. More than 20 districts that have received this CB support. CHECK AGAINST TRAVEL SCHEDULE.

Trained HW who supervise community volunteers for nutrition. MEET WITH NUTRITION VOLUNTEERS. They hold community meetings where sensitize chiefs in community who take part in availing food, ensure that mothers take their children for growth monitoring. Have seen good support from community leadership in two districts in particular (not where we are going).

HIV and nutrition has been a critical intervention; a lot of mixed messaging concerning feeding, mother's choice affected by other family members. Added a component to strengthen counseling skills of volunteers on HIV and nutrition.

KBs: MCD MOH training institutions (how?)?????

Major Activities and CB:

Nutrition:

Assisted the National Food and Nutrition Commission to develop 8 policy briefs for stakeholders to facilitated implementation of First 1000 Most Critical Days – maternity policy and…

Developed Maternal and Adolescent Nutrition Guidelines for HWs

Helped NFNC to form 5 multi sector coordination committees for improved coordination in collaboration with NFNC (Mins of H, Ed, CD/MCH, Agric, and Local Govt and Housing) ADDRESS THIS IN COORDINATION EVALUATION QUESTION. INTERVIEW WHOEM?

Supported development of strategic plan WHERE? Relationship between committees and SP?

Assessed 25 HF in 5 D on BFHI – results: (see AR 2012)

Trained HW in IYCF (50/50 gender balance); trained community volunteers in C-IYCF and CBGMP (also gender balance – INITIATIVE OF ZISSP TO COMBINE THESE TWO TRAINING PACKAGES – ASK MORE ABOUT THIS); trained HW (gender balance) in nutrition and HIV. Did ZISSP ACTUALLY TRAIN OR PROVIDE FINANCIAL SUPPORT FOR TRAININGS? ADD TO TRAINING QUESTIONS.

EPI:

Situation analysis of RED strategy in 40 HF in 14 d to decide where to focus efforts, was a MOH priority.

Reviewed and updated training and monitoring tools for RED strategy

Oriented OJT 60 provincial trainers in 20 districts in RED strategy

Trained 259 HW in RED strategy out of which 50% received mentorship (??) WHY ONLY 50%

Linked with PMTCT initiative how at community level?

Have seen immunization drop out rates reducing as a result of active roles of defaulter tracing who are the community volunteers.

Are immunization volunteers same as SMAG volunteers?

ASK HC ABOUT REDUCTION OF DROP OUT RATES.

IMCI:

Strengthened the Newborn Care Guidelines and Scale up Framework; pre service: in service: trained nurse tutors and clinical instructors from 12 nurse training institutions as trainers in IMCI using the IMCI Computerized Adaptation and Training Tool (ICATT); trained HW in IMCI in 18 districts.

ICATT – adopted how for ZISSP? ADD TO TRAINING QUESTIONS

Now an 8 day training.

IS ZISSP TRAINING DIRECTLY OR SUPPORTING MOH TO TRAIN?

Mushrooming of private training institutions, especially nurse training instituions, need to standardize this tool as part of their training curriculum. What is ZISSP Plan to do this in remaining project period?

Self paced training. Hope that with other donors who can pay for computers for schools, each student can complete this training. REVIEW THIS TRAINING MODEL ONLINE. Useful tool for people who cannot leave their desk, including people in private sector.

Challenge to retain female HW in rural areas. So slight gender imbalance in IMCI trainings for HWs.

In terms of improving case management practices in HFs, ORT corner and ?? corner: opportunity to reinforce messages with mothers. This is an area in follow up visits that is documented as a weakness. Diarrhea seems to be re emerging as an area of emphasis for ZISSP and other partners.

There are opportunities to add new ICMI elements and messages to corners where they exist and build linkages to community resources.

KP: included NFNC, WHO/UNICEF, CARE, SAVE, PATH INTERVIEW THEM IN FIELD VISITS?

Questions:

What is ZISSP trying to do to and beyond qualifying BFHs? To qualify, need to avail training, fills gaps like materials, policies, messaging, etc. Once HFs have been upgraded, who will create demand so that mothers bring babies to HFs? There is NFNC BCC team to do this.

ZISSP has come up with 10 steps for successful BF poster and fliers distributed to HFs and surrounding communities by ZISSP volunteers to create demand and reinforce standards. BFHI is not meant to be a HF because now it is BF, it links up with institutional deliveries, idea is to ensure that if baby is born there, HF is able to address early initiation of BF, exclusive BF, (review criteria), rooming, keep baby next to mother so can BF at any idea. This initiative was adopted by Zambia many years back, so if HF was assessed, where there gaps, they are addressed until HF qualifies. Like an accreditation process, but over the years, accreditation standards and gains were lost. So idea was to first do assessment for current status, supported by ZISSP. This was in plan for MOH to go back and reassess. Based on findings now MOH together with partners including ZISSP, will look at strategies to revamp HF BF status.

Report conducted end of 2011 and report in 2012. Where are things now?Next step is develop the strategy. An idea for SS, mandate is to work with GRZ partners to help them have evidence to address needs and gaps.

Do community nutrition volunteers do cooking demonstrations or counsel on how to optimize nutritional content of local available food? Are nutrition volunteers different from SMAG volunteers?

IMCI: ICATT – adopted how for ZISSP? ADD TO TRAINING QUESTIONS

Nutrition volunteers are part of SMAGs. As part of GM they identify children who need more intense interventions, they are trained to prepare local food and get into feeding sessions. Will follow up specific mothers to do community cooking demonstration. WHAT STRATEGIES ARE PROVING MOST EFFECTIVE?

Schedule follow up conversation about this.

Volunteers do follow other up in households, ensure that they report for weighing sessions to see if there are improvements. HOW DOES THIS LINK WITH NACS AND INTENSE FEEDING PROGRAMS FOR MALNOURISHED children?

Use Saturday to review materials? Use Sunday to develop report outline?

REQUEST COPIES OF RED STRATEGY MONITORING TOOLS.

What monitoring is happening at community level (broad question)

Where we have greatest need for monitoring is for nutrition from HFs.

Training starts with HWs, they select community volunteers to then undergone training for them, for skills reinforcement they go in turns

Opportunities for HWs to go t communities and assist them during GM, have noticed that under 5 registers at community HF are weakest in terms of data and updated info. DO VOLUNTEERS ENTER DATA IN THE HF REGISTERS?

SMAG registers and UNDER 5 registers are different. THERE ARE SEVERAL REGISTERS.

Do HWs have transport for community monitoring? vehicle? Fuel? Time? D supposed to provide transport or fuel; could mentoring teams play a role in supportive supervision for community volunteers?

NHC is an important structure to be general overseer of community volunteers. Given new CHAs, this is an opportunity to ensure that they are supported to provide technical oversight for community volunteers. They are given bicycles for transport.

More about formal relationship between CHAs who are new and cadres of volunteers, some of who have been in place for a long time. This challenge goes beyond ZISSP, issue of ensuring that community volunteers provide quality services. Intended supervisors are HWs at HC level; if you are lucky you will find and EHT, clinical officer and nurse. But in more rural HFs you will find one or two, no time to supervise. To extent that program like ZISSP can assist to improve linkages? Systems? Supervisory trainings? Whether that support translates into their capacity to do the tasks is another question since capacity is not the only issue.

Beauty of this program is that we are working within the structures of MOH. We do recognize need to ensure that first you have the tools, capacity of HW staff, not only skills but also so availability.

But can't place additional HR personnel for this role. It's a work in progress.

5th orientation with ZISSP April 15, 2013

Malaria:

Malaria team: Brian Shiba, malaria TL: Patrick Jewe, M&E malaria; Justin Chongo Logistics Adviser, Charles Nyandu, Procurement Manager for AIRS; Dayton Makusa IRS Manager; Musapa Mulenga, Entomologist; Benjamin Winters, with Akros – active case surveillance protocol Lusaka District and active infection protocol and M&E component of IRS, and entomological surveillance. Matthew Burns in field now.

Malaria still main public health challenge in Z, leading cause of M&M, affects mostly young children under 5 and pregnant women. Main priority in both national health strategic plan and national malaria strategic plan.

Key Strategies for ZISSP:

Support IRS in 20 districts (previously3 5 up to Dec 2011)

Malaria prevention and case management with emphasis on children under 5 and pregnant women

Active infection detection in Lusaka district

IEC to support IRS and intermittent preventive therapy of malaria in pregnancy (IPTp)

IRS:

Conducted in 20PMI supported districts plus …"all districts"?

See slides for details.

Requires strict environmental compliance, managing insecticides and insecticide resistance.

Want to ensure that at least 90% of malaria patients receive prompt effective diagnosis and treatment according to current guidelines by 2014

At least 90% of all pregnant women should receive IPT by 2014

All case should be confirmed.

IEC: community sensitization to improve IPTp uptake, improve national ACT uptake, other.

Artesimen Combination Therapy

Key Activities:

Trained 5,457 to deliver IRS (both operator sand supervisors)Trained 531 trainers for IRS sprayers.

Developed team of master trainers/national facilitators to offer TSS.

Trained 4,926 spray operators under cascade trainings (?).

Distribution of IRS commodities: insecticides and personal protection equipment to IRS districts.

Safe disposal of insecticide waster

Enumeration of household structures

Developed SOPs for IRS commodities aimed at enhancing accountability and tracking of commodities

Supported TWGs to provide technical guidance to NMCC: IRS, Insecticide Resistance Tech Advisory Committee Malaria Case Management, Malaria M&E.

Routine entomological monitoring and resistance studies in selected districts – detected resistance to DDT, pyrethroids, and carbamates in some places. Map that shows southern Africa region and

recommendations; Zambia recommended for organophosphates, more expensive but only have to spray once.

Provided capacity to collect entomological data in 20 districts

Trained 54 EHTs in entomological monitoring and resistance studies, created 6 sentinel sites for investigations, maintained national entomology lab and insectary, including Lusaka and Kitwe.

Introduced malaria guidelines as source of reference material to health workers

Conducted Malaria in Pregnancy (MIP) assessment to understand factor that facilitate and inhibit the timely use of IPTp inZambia: found that only 48% of health providers were orientated to FANC; trained 4533 against a life of project target of 1,650, representing 26% achievement

Implemented use of organophosphates in 3 provinces.

Improved community health volunteers skills in community health care management: trained 622 community health volunteers FOR ICCM.

Established malaria active infection detection in Lusaka district: visited more than 1,500 households, tested more then 5,200 people, recorded 1.6% positive rate in participating clinics, handed over 5 clinics to Lusaka DHO (what is involved in handover? Any ongoing support after handover?)

Key partners: MOH MCD PMO DMO private companies mines and sugar, local authorities, Tropical Diseases Research Centre (TDRC), Malaria Institute – Macha, Malaria Control and Evaluation Partnership in Africa (MACEPA), based at NMCC. WHAT IS CDC DOING WITH MALARIA IN ZAMBIA?

From malaria indicator survey 2006, 2008, 2010, led to active infection detection activities in Lusaka, incidence so low that Lusaka was dropped off? Showed that overall incidence going down, but still high areas. CDC doing a lot in malaria, too. Entomology for example. Have a doctor from CDC here to work with Musapa to work on entomological resistance.

Another person also doing technical backstopping Kathryn Tan with CDC.

Malaria is mostly found in eastern part of country, divided right down middle. On western side attempting to maintain gains. So spraying focused on eastern side.

Zissp supported training of operators, supervisors, distribution of commodities, overall planning, monitoring and supervision. Gov, WB and GF funded other component of implementation and operational costs. Even in PMI supported districts, that was the approach.

Specific selection of 20 districts was from director of public health and research who suggested area of high incidence where districts are contiguous, benefit from transport efficiency, and result more observable than across scattered districts.

Given that less than 2 years remaining, what's the plan after 2014? This is a costly program, unlikely that gov will take it over. Last year gov decided to spray in all 72 districts, but could not for various reasons, main one being funding limitations. ZISSP did cover all districts committed to, gov not able to, didn't procure supplies on time even with donor support. Last year was WB's last year to fund spraying.

For goal of receiving IPTi, goal is to receive at least 2 doses.

How's the RDT supply? Intermittent. Good except fluctuations in 2012 latter part of year, fluctuations in distribution, starting with November supply has been erratic. Big challenges.

How long before mosquitoes become resistant to organophosphates? Mosquitoes sometimes already develop resistance even before a chemical is used for spraying, maybe developing because of use as pesticides. Here try to select chemicals where mosquitoes are still susceptible and then rotate them.

What's relationship between long life nets (insecticides) and spraying insecticides?

Are people supposed to pay fee for house to be paid? This is with private sector, for our program don't pay anything.

In Lusaka there is a fee paying spraying program; yes, people have been going to households asking for fee to spray, this is a private enterprise. Not basically for malaria. It's for other vectors. This is extermination service, but is supported by Lusaka DHMT. (verify?)

CDC doc: this should be illegal. Insecticide resistance management groups should be monitoring use of correct chemicals, these people are not authorized to sue whatever they are using and could be creating resistance problems. This should be illegal. Long ago, a control scenario was run in Zambia and look at a fee for service for IRS, thinking that might add to sustainability by cycling through private markets. They found it didn't work and recommended against it. Don't tie baseline PH interventions for malaria to a fee for service model.

Has been discussed with private sector in past, although no decision was made as to how asking people to pay could work. Will have people who cannot afford to pay and they will be left out of spraying.

Wont' be complete coverage, won't be effective if leaves out people who can't pay.

Primary concern for Z's overall malaria management strategy is probably targeting and increased focalization within that targeting. We have good epi data to support lack of IRS in Lusaka district, positively rate and overall prevalence rates are low enough to use more focalized response there.

We need to assist gov to recognize data points and choose not to spray where not needed.

any other mechanisms that try to link up more revenue flows from IRS activities, will be a problem.

ZISSP will try to push proper insecticide distribution and assist with choice to spray or not to spray, this can same millions of dollars over a 5 year period. Part of rationale for increased case detection; if you increase quality and timeliness of your data flows, have a better framework from which to assess which intervention makes sense. This is good support to government.

Not just Lusaka district the strategy of jumping from all districts all communities rather than setting priorities and costing the focalization is a big barrier to sustainability.

Who is F for CCM or ICCM on team? **FANC and ICCM and CCM don't have focal persons, so currently fall under the Team Leader.** Used to be that malaria team leader was clinician, now not the case, left about 4 months ago. Had the position posted to hire another clinician for CCM in particular. Didn't have success yet. Going to re-advertise looking for a Clinical Officer.

Acute shortage of doctors. Market for doctors is problem in Zambia, most work in public sector, as USG programs not allowed to recruit from public sector. **In field must supervise medical doctors, so difficult to hire a CO or nurse to supervise them. This is a key difficulty ZISSP ha faced in filling clinical care specialist positions with non doctors, since they supervise doctors. Big challenge for ZISSP in filling vacancies.**

CCSs in province are spending a lot of time to work with malaria.

Could you achieve your project malaria objectives just through the CCSs rather than attempt to have a central clinical officer for ICCM, CCM, FANC?

A lot of what this person does here at central level is organize trainings, not conducting the trainings. Think we do need someone at central level but may need to be more flexible about whether person is a doctor. GET THIS JD?

This is exactly what we have been discussing, someone who can COORDINATE the FANC, ICCM, CCM activities at central level, maybe a training specialist/clinician? Then the CCSs who are doctors can handle the supervision aspect.

During 1st quarter, after team leader left, didn't have somebody to coordinate the CCM trainings, in working together with NMCC, they saw no reason why we should struggle to get someone to do this, they said a more sustainable solution might be to work within existing structures, and they chose to coordinate the activity themselves. MAYBE ONE OF THE FIRST THINGS TO TURN OVER? They coordinated, they used doctors from provinces for trainings?

What was ZISSP teams involvement in MIS? Involved in planning aspect, training of participants, monitoring and supervision in the field; one of collaborating partners, not the lead. We had specific roles: procurement, funded part of transport and supplies; provided TS to train enumerators as well as lab techs and nurses collecting and entering data; provided monitoring and supervision support.

Next one is 2015, so ZISSP's mechanism will be over. But will start planning in 2014? Primary support partner MACEPA may or may not choose to provide support going forward. Talk with John Miller about that.

What? will eventually become Zambia's malaria database. As data flows increase, the need for a sample survey becomes less and less important. MACEPA is wondering whether future MISs are a good investment.

Sustainability: an area where malaria team has made a good mark. When we closed out previous program, HSSP, we were given 8 months cost extension to continue spraying until program was put in place, reason was that there wasn't sufficient capacity built for continuity. One role of HSSP and now ZISSP is to build capacity of NMCC as well as at P and D level so that IRS program be implemented smoothly. When ZISSP came on board, we began strengthening all levels with big focus on P and levels. AT P level do have chief and ? officers and master trainers, and supervisors at D level. When training is organized, would see these ZISSP guys doing the trainings, now the master trainers are doing with TS from ZISSP seconded staff (IS THIS BUILT IN AS QA?)

When NMCC asks for training support, we refer the now to these gov trainers who are now in place.

We talked briefly about ICCM; ZISSP's role has been to train supervisors from HCs in supported districts. We train HWs and community health workers/CHWs, we train them in CCM, challenge is to see whether and how they are implementing. And ensure that focus is on malaria, diarrhea, pneumonia. HCs receive commodities through supply chain, problem has been stock outs, if you look at what is contained in the kits, we are told that 5,000 amoxycillin is for catchment area and CHW is supposed to get supplies, so there are frequent stock outs, same with RDTs. Do not have them at center, so community is affected.

Protocols for ICCM, who developed? Using WHO? Yes. Supervision and monitoring tools were developed with stakeholders together, ZISSP participated. SAVE the Child guidelines?

There are efforts to make a decision tree for clinicians to give an alternative to what would be called malaria symptoms. CDC is looking for more specific framework for Zambia. This is IMCI. Would this be under purview of CCS or CHC? CHCs not medical doctors. But have public health background, have community experience.

Is there direct relationship between NCMM and health promotions team regarding malaria? Do you interact with health promotions office at NMCC? Yes.

Performance Monitoring and Evaluation Plan (PMEP) – get slides

ZISSP has 2 types of indicators
1. COP, IIP, MOP indicators, quantitative

2. Program Performance Indicators (PPIs) both quantitative and qualitative

Data collection: mentorship forms adopted from MOH, training registers, and HMIS: Vit A and DPT3.

COP, IIP, MOP Indicators:

HCWs that complete in service training program: 4 areas: clinical care, HRH, MS, BCC

new HCWs who graduate from pre service training institution (CHAs)

people trained in FP and RH: HW (nurse tutors/nurses) and CBDs

people in trained in MNH: EmONC (health workers); SMAG master trainings, SMAG volunteers

people trained in child health: HW (ICMI), IYCD, RED)

community health volunteers (Community IYCF, C-ICMC)

children who received DPT3 vaccine by 12 months, and % of children who received DPT3 vaccine by 12 months, %age difficult because of variance in denominator data, to get this must do randomized cluster survey; these indicators came during pre proposal period.

Reason these indicators persist is because USAID has several indicators to report to DC and this is one of the standards. They recognize that ZISSP can't influence ….THIS IS PROBLEMATIC; ZISSP CANNOT ACCURATELY REPORT THE PERCENTAGE.

DPT3 data hasn't yet been collected for the 2012 DHS. ???

Not something ZISSP is making a major contribution to with our resources; just a standard indicator that falls under child health globally.

In indicator narrative the reports clearly define the limitation for this indicator. CHECK THIS.

children under 5 who received Vit A

people trained to deliver IRS/supervisors and spray operators

houses sprayed, # houses targeted for spraying, # HW trained in IPTp

When you go to enumerate you can enumerate more than what you are going to target. Based on several things: may enumerate whole district, but may only decide to target hot spots, will be smaller than enumeration of whole area.

When you enumerate you count the # of houses actually there. targeted vs. actual. It does happen in a few instances where targets were given based on assumptions about population and # of people in household, before district is enumerated. Then the enumeration gives actual figures. District is advised of difference. Do readjust targets based on actual data Do adjustments flow into reports? May be more or less households than you originally thought. Useful to report when you exceed targets.

Real issue is seeing whether houses you sprayed are the ones that you targeted. During PMI commodity audit last year, became aware that other places were also sprayed to reach the number. If refusals mean that you aren't reaching the original targeted households….interrupted. Data includes # of refusals and reasons. IS THIS LINKED WITH IEC OR BCC CAMPAIGNS TO ADDRESS REFUSAL REASONS?

people trained in malaria case management

Volatility in the denominator. May not reflect intended households, usefulness of indicator is brought into question.

If DHMT doesn't pay allowances for sprayers to go to far, they won't go to targeted areas, sprayers will go to other areas in same catchment area but not so far. So now trying to hire sprayers from these community so sprayers from far away don't have to go there and camp. Seems to be working well. District supports this strategy.

Instances where started with certain district, then politically it was divided, so changed spray target areas? Yes, had to go into new districts because of re mapping? Mafinga became Soka or vice versa? When training was happening, had to be split. From operations point of view, still view them as one district.

Have some houses that need to be sprayed once a year, others twice a year. In phase 1, count them as one. In phase 2, will split them. What %age have to be sprayed twice? Used the carbamate in 2 provinces, N and Machinga. Only there must be sprayed twice -13 districts. They call this phase 2.

Program Indicators GET THIS SLIDE!!!!

See slides. THESE ARE SYSTEMS STRENGTHENING INDICATORS.

# of improvements to polices etc., -that MOH adopts, implements, or institutionalizes with USG support. HOW DO YOU MEASURE IMPROVEMENT? ARE YOU DISTINGUISHING BETWEEN ADOPTING, IMPLEMENING, INSTITUTIONALIZING? In indicator narrative, we have specific definitions for every term used. Although initially put under program, got from the XXX people, not required to report on this. Way

PRODUCTION; # of policies, etc that are developed, reviewed, signed/approved, published, and/or disseminated with ZISSP support.

USAGE: # of program manuals, guidelines, protocols or curricula that are available and IN USE FOR 5 technical areas and for cross cutting topics (HRH, QI).

Example: planning handbooks are at various levels, so we count each one independently.

With these indicators, the emphasis is on qualitative information on our contribution, the improvements, and stage of improvements or progress or status.

Example, clinical mentoring guidelines are being used at district level.

Q: Those things you promised USAID you are going to do are the key indicators. Are these proxy indicators?

We have mandatory and optional indicators: these are the ones that Zambia has selected to report to DC. These being presented are internal, are ZISSP's. We are counting a contribution when adoption or implementation or institutionalization happens. These are useful SS milestones.

The clinical mentoring guidelines and training materials rest on foundation of clinical mentoring system that was established under HSSP especially to support the HIV ART program. Everyone recognized not effective to mentor only under one technical domain; ZISSP broadened the mentoring focus to other clinical areas. HSSP developed the model to focus on HIV, and there were different partner tools. Partners had developed in HSSP era different tools for ART mentoring. One effort was to harmonize donor funded programs, do it through one common mechanism, the clinical care team at District and Provincial levels rather than having donor funded project teams going out to do clinical mentoring.

We are somewhere along spectrum toward implementation. Can see evidence that are clinical care teams in districts now evidence that QI teams are being formed. Another one of areas of improvement.

At what point tried to measure # of clinical care teams formed with support from ZISSP not being tracked? Trying to track existing or functioning teams, since had already started under HSSP. Sold this idea to gov, was adopted by gov before HSSP ended.

Would be good for evaluation to know how many teams ZISSP helped to form.

The above indicators relate to Task One.

Proportion of target districts that monitor district action plans, revise activities and budgets quarterly to reflect performance and resources. Proportion of MLA participants enrolled for 5 months that complete all 4 training sessions. Attrition rate? Can make up a missed module later on. There have also been specific make up sessions. This program was designed to have short, quarterly classroom sessions with mentorship in between. Scattering training over year has its own set of problems – mobility, what else?

Proportion of districts with trained CCTs that have fully or partially funded Clinical Care Teams (CCTs) (AIM IS ONE PER DISTRICT). Within CCT there should be child health expert, EmONC expert, etc. a resource pool,

Proportion of ZISSP target districts with district health action plans that include any interventions included in the Adolescent Reproductive Health Strategy.

?? Form is filled out when district is establishing the team. Are you looking at composition of team or just at whether team has sufficient members? What constitutes functional? How likely is ti that you have functioning experts in all technical domains due to attrition? Can teams remain stable over time due to turnover, etc. Who can fill in?

Started implementing WHAT? beginning of 2012; started using it in draft form.

# of HCACs that have been trained in community health planning, have prioritized community health issues in community action plans and implement at least 2 of prioritized activities during course of the year. Have HCAC members been trained in community health planning? Are community action plans in place? If so, have at least 2 of the prioritized activities been implemented? Can measure this at end of 2013?

The thing to know is that the planning cycle for activities that could have taken place in 2012 happened from June 2011. Would have to look in data set for people who are trained, HCs where you would expect it to have happened are those who were trained in planning before planning cycle in 2012. Get trained, then hold meetings to make plans. So number will be small. Expect that number will go up in 2013 and by end of project. Could check in some HF that they have made a plan, have some priority areas, may have started to work on them. These are not stand alone plans, these activities integrated into the HF plan.

Community plans fit into health center plans, which fit into the consolidated district plan. It will be revealed in the District Action Plan. KP thinks the HF is place to find the documents. Should be able to see planning they did at each HF. The community activities in the HC plan.

Proportion of target facilities with trained SMAGs.

# of private companies and/or NGOs that have been engaged in HIV/AIDS, FP, malaria, MNCH or nutrition services through PPP and any other types of partnerships.

We have received a list of all of their indicators, both mandatory and additional internal.

Primary difference between two sets of indicators is the time period.

For MLA proved difficult to get all 4 sessions done in just one year.

Paul: there are more indicators in your original PMEP. Where are they?

First year of Z mission management was completely differnet, and collective personality of mission changed in second year. New director put more stock in importance of reporting indicators. Her concept is revise indicators where needed to reflect changes in environment. Her importance is to reach targets.

Zissp has revised the PMEP 3 times since project began. Our indicators in the revised workplan submitted to USAID is inconsistent with these indicators, so have sent the evaluation matrix to ZISSP to revise.

Group Meeting with ZISSP Clinical Care Specialists

May 27, 2013 Interviewers: Beatrice and Jean

- The overall project is supposed to have 9 CCS but currently only 7 positions are filled.
- Present in the meeting were CCS from Copperbelt, Eastern, Northern, Southern and North Western provinces
- Absent from the meeting were CCS from Central and Lusaka provinces

  Quality Improvement

  QI is done in the Core clinical technical areas e.g. IMCI, maternal health, child health and EmONC
- **QI process:** When a problem is raised during the Performance Assessments, e.g. when pregnant women are not tasted for syphilis- the QI committee is informed and a visit is made. Or if it's due to limited capacity, then mentorship is provided. If it is an issue with Medical Stores Logistics, lobbying is done. If an order of RPR kits does not show up, the provincial CCS should be tasked to follow – up with the provincial office. CCS have had discussions with Pharmacists who are part of the QI team. During QI, registers are checked, the team goes through the data to check for things like confirmed and clinical malaria cases. The district gives a weekly incidence report such as RDT. Right now there is no Nevirapine for PMTCT. The QI teams also go round conducting TSS on data use and some districts are now being responsive. The have also started evaluating the MOH selected QI indicators. QI indicators do not include family planning.
- **CCS role in RED strategy roll out:** RED Strategy training is conducted by Mary Kaoma the ZISSP MNCH specialist based at national level. CCS assist with. ZISSP is not fully involved in routine immunization, but provide planning and financial support during child health week.
- **Regarding outbreaks of vaccine preventable diseases:** Yes – Measles and was attributed to breakdown in cold chain especially in valley districts due to high temperatures.
- **Routine vit A:** Trend is to wait for child health week and this is challenge.
- **Data interpretation and use:** An example was given about Gwembe district where they realized that they were not meeting their fully immunized targets despite scaling up outreach activities. When CCS visited, she checked their registers and discovered that BCG vaccine was derailing the fully immunized figure because HWs waited for 10 children to open the vial.
- **Mentorship:** This is provided but it needs to have enough skilled mentors to bring it to scale, and cover all districts in the province.
- **Model sites:** MOH in collaboration with ZISSP selected some sites in ZISSP districts but found that some ZISSP-supported facilities had no qualified staff and this led to ZISSP taking on facilities in non ZISSP districts.
- **MCH:** Losing a lot of mother baby pairs due to weak community/facility links. CCS - will collaborate with CHCs who support SMAGS, lay counselors and UNICEF Mwana program on the Copperbelt. BU facilitators are tracking their facilities.
- **Issue of training/verses supplies:** ZISSP is compelled to training even in absence of equipment and supplies for example, IMCI is about referring a child who needs it even if there is zinc, or other drugs- so training is justifiable- at least some HW will assess and refer

- The CCS mentioned they had done a needs assessment but we were not sure which needs assessment was conducted.
- **Collaboration:** QI training done at provincial level, Mansa for example- pushed in own funding to train 31 HWs- cost sharing, developed QI training package in collaboration with CDC, MOH visit to SMAG districts and conduct training together, PHO- CO funding some activities such as payment for allowances, worked closely with CIDRZ on development of Misoprostal guidelines

- **Bi – annual PA**: Not yet given guidelines- so has not done but sites identified
- **Have you participated in site accreditation:** -Yes site preparation before accreditation – was in last year workplan but not done
- ZMLA: Is a good training - need to increase number trained to include H/F managers. MOH should take it into pre-service.
- **Challenges:** - They have had limited financial capacity, most guidelines started being developed in 2011

Interview with MOH Directorate Technical Support Services

Date:	April 17, 2013
Informant:	Dr. Mulega, Deputy Director
Ministry:	MOH
Directorate:	Technical Support Services
ZISSP focus areas:	Performance Assessment (PA) Review Tools Technical Support Service to address issues identified in PA Reviews Zambia Management and Leadership Academy
Interviewers:	Jean Capps ZISSP MTE Evaluation Team Leader Kumbutso Dzekedzeke, ZISSP MTE Evaluation Team Member
Technical Areas:	This office is responsible for governance and systems in the provision of services by the MOH. These are crosscutting areas not specific to ZISSP interventions of interest MNCH, FP, HIV/AIDS, malaria, or nutrition. "We have oversight, but we don't directly implement programs."

The Technical Services Directorate is responsible for Pas. A closely related area of technical services-Quality Assurance falls under the Clinical care Directorate. PAs takes a multi-disciplinary approach and has been in use for about 5 years. They monitor a set of key MOH indicators at multiple levels of the GRZ health system. PAs are done twice in a year in the first and last quarters.

His office looked at reviews of semi-annual performance reports and identified poor problem identification and poor project management skills as priority deficits. One way identifiesd to address this problem was the ZMLA. The ZMLA was started in 2010. Under the ZMLA, participants are trained in pairs of district-province and national level-province. They are exposed to concepts of management so that everyone in the districts, provinces and the national level are appreciate the need for cohesion when delivering services. The ZMLA courses are carried ou in the provinces. The province decides the time when the

trainings will take place. Then a team of mentors from the Ministry of Health, BRITE and the National Institute for Public Administration travel to the province

PA is a multi-disciplinary approach. "PA gives us the chance to assess things from multiple levels." The district monitors health facilities under them; provinces monitor districts, MOH headquarters monitors provinces. Used as a supervision tool but also provides opportunity for capturing and sharing lessons learned and best practices. ZISSP assisted the TWG developing PA review tools. They are finished but not yet fully implemented because the districts are now under the Ministry of Community Development Mother and Child Health. A modality for the two Ministries to work together to address the problems identified during the Pas is being developed. He feels they will be implemented before the ZISSP program ends.

ZISSP helps take information from the PA reports and help develop technical support to address the issues that are identified in the reports. (Need more info on this). See more on ZMLA below. They teach technical support and health facilities have a self-assessment tool form. They review these forms and see if issues make it into action plans and whether action plans are completed. (Joint MOH and NIPA). This is used for developing mentorship.

ZMLA is operated out of this office. ZISSP (specifically BRITE) has done a great job and the training is really needed. Participants are located at the central MOH in Lusaka, and in provinces and districts. Too early to link PA report results directly with the ZMLA training because they haven't graduated yet. He has heard anecdotal feedback that the training "has them thinking of things they weren't aware of" or "we were never asked to do these things before". EGPAF and other programs have wanted to do similar things but they only wanted one program. ZMLA works closely with NIPA and in the long run, NIPA should eventually take this on because it has the capacity to conduct such trainings. The ZMLA programme was also given accreditation by NIPA as the institution responsible for in-house training of civil service personnel In the past, NIPA used to train MOH personnel in management in a six months course

For sustainability, the "Provinces" must "own" the program. He likes several features of ZMLA including Provincial peer-monitoring as a training follow-up. PMOs monitor another PMO outside of their own province. He thinks that "when a PMO knows that one of his classmates is coming to monitor him, he may hurry to fix some of the deficits before his peer-reviewer arrives." He would call it an "indirect benefit" of the methodology. The problem with adhoc training programmes such as ZMLA is that they can not train enough people in a sustainable way. Personnel in the civil service are rotated and others leave by other attritions. Then they are replaced by new ones not exposed to ZMLA. These new ones are the weak links which negate the ability of the trained ones. Curriculum such as ZMLA should like all trainings be institutionalized in basic training institutions of medical personnel. This way, everyone in the health sector would have been trained and the new ones would not be a weak link.

One problem with governance of the health sector is that the community structures such as SMAGS and Health Centre Advisory Committees operate without legal backing. This fell away when the Central Board of Health was abolished. When its Act was repealed, the new law did not carry the communities structures. The Ministry of Health is currently working to give the communities structures a legal mandate again. This is advanced and the Ministry of Legal Affairs has already made drafts of the necessary amendments. (Interesting

comment) "HCACs were from the old (Medical Board) system. They were abolished, but they are there."

Many of the trainees come from the provinces. Some of the TOT must come from the province. This separates the supervisor and mentor roles that can confuse the efforts to improve performance.

They have several MOH challenges to seeing the full impact of the ZMLA capacity building efforts including transfer of participants (often to other ministries!) Some offices strengthened at one level have no direct relationship with the corresponding office at another level (used "accounts" as an example). M&E is an issue, esp. in health and is often created in a vacuum. He couldn't provide specific PA reports with personally identifiable info, but offered to provide synthesized reports. (We would have gotten them at the time, but he couldn't transfer to Kumbutso's modem. We need to remember to try to pass by and collect them.

As a government agency, they often have legal barriers (laws) or government mandates that can be challenges to implementing new (implied innovative) approaches.

"ZMLA is a government program. It is important, but we need a program like the six month program many of us attended at PEDESA to be available here in Zambia. NIPA is probably the best place for it to be placed."

"Many projects come into Zambia with a program designed for another country and just want to implement it here (implying the ZMLA is different because it is their program)."

There is "too much repetition in donor programs." "I made ZPCT2 and ZISSP sit down together and coordinate because they wanted to do similar things."

Bottom line on ZISSP and ZMLA "What they have done is truly remarkable"

Key Informant Interview
MOH Planning and Budgeting Office
Date: April 18, 2013
Informant: Mr. Mubita Luabelwa, Deputy Secretary, Planning and Budget
Interviewers: Jean C. and Kumbutso D.

Roles of the office of Planning and Budgeting:

1. Monitoring and Evaluation
    - ICT: including SmartCare and Record Systems
    - HMIS
    - Hospital HMIS
    - District HMIS
    - Joint Annual Reviews with Partners
2. Policy
    - Legislation
    - Parliamentary – "Putting it all together"
3. Planning and Budgeting
    - Bilateral and Multilateral Coordination

SWAPs, NGOs, Private Sector (PPP is in national policy)

- Infrastructure
  District Hospitals, Health Centers, and UTH (There are 1,800 Health Institutions)

- Annual Planning and Annual Health Budget
  Budgeting but not payroll, payroll is now centralized and people get paid on time
  WHO says we have made Abuja commitment of 10-11% for health; but military and local government health expenditures pay for a lot.
- They use WHO definition of Health Systems Strengthening. National Health Systems Survey uses those 6 systems.

ZISSP's assistance to MOH:

- National Health Accounts: mapping and spending from all accounts: ZISSP provided a very good consultant who helped us with this.
- Planning and Budget
  Planning Process – Hospital Handbooks, District Handbooks, Headquarters and Provinces
  Simplified the use of handbooks
  Provided technical updates
  Grant support teams to the provinces (?)

Collaboration has been good in planning process and planning handbooks.

- National Health Accounts: ZISSP paid for good accountants to help us to develop a national tool for Marginal Budgeting for Bottlenecks (MBB). The TA was very good. There was great flexibility in their Tech Support for budgeting. "ZISSP came in to rescue the boat to overcome barriers to the National Health Accounts."
  "We had a lesson learned to not delay in the National Health Accounts". "The (Ethiopian) consultants were very good". They helped them to reconcile NHA from several years' backlog. "We are now fully involved but not quite ready to do it 100% ourselves. We still need a consultant to help us but we are doing most of it now. Our management was sort of ad hoc."
- He recommends additional work (remaining time in ZISSP) in joint planning and implementation. "Zambia produces fewer than 100 physicians per year but we pay better here now than Botswana". The base pay is $2000 per month plus many bonuses such as paid housing. When the (doctors) threatened to strike, we said "go ahead", we'll publish what you are paid in the newspaper and nobody , "will support you."
- ZHWRS – "Still in existence." He thinks it works, but the challenge is, "How do you define a rural area?"
- His office shared their Action Plan with partners earlier this year (2013). "We are waiting to hear back from them and the National Health Accounts this year."

Meeting with Society for Family Health – June 11, 2013.

Met with Namwinga Chintu, Executive Director. Interviewer: Beatrice C.

- SFH works in the areas of Service delivery and sales and distribution.
- Have dedicated providers placed at health facilities to provide services, but also train MOH staff. SFH has a CBD model which has helped them to push up contraceptive utilization numbers. ZISS can collaborate with SFH to learn about this model which encourages and uses social marketing approach. Commodities are given subsidized prices to the volunteers and they retain the profits. Start up loan is provided which is paid back.
- Collaboration with ZISSP - Together on the FP and EmONC TWGs - and ZISSP drives the agenda. ZISS has played a key role in EmONC training and support for services
- SFH is trying to collaborate with ZISSP on use of SMAGS to create awareness of Misoprostol. ZISSP has an excellent Monitoring tool for SMAGs and SFH would like to add on a picture representing Misoprostol.
- SFH distributes ITNs branded as Mama Safetnet. They have trained CHWs who provide health promotion. Could also work with SMAGs on ITN distribution.
- ZISSP is a partner that is easy to work with and pushes on things. In fact whatever is happening with the SMAG program is owed to ZISSP for their continuous engagement with all the SMGL partners and coordination of partner activities.
- At Chief of party level, KP and I are on constant discussions.
- SFH collaborates FP training with ZISSP to ensure there is no dublication of efforts e.g. training the same people.
- SFH uses the national supply chain for products such as IUD, Jadelle and commodity stock-outs have occurred but not frequently. For Oral contraceptives and female condom, SFH uses branded products and the female condom has very low utilization level.
- ZISSP organizes quarterly partner meetings where National AIDS Council is a member.th ZISSP but have joint partners meetings every quarter
- SFH has not conducted any joint training.
- SFH provides Jadelle insertion and removal kits in their model sites. Also provide outreach services. She is aware that in some facilities, kits are a problem.
- She stated that it is important to increase community based services including training for infant ART. MCDMCH wants to see this community shift. For example partners have been pushing for volunteers to provide Misoprostol at community level – but MOH sees the cadre as too low to give this kind of drug.

Country Ownership

- Still weak on GRZ's part. CDC is however using the COAG approach – funding GRZ directly.

Meeting with ZPCT II June 11, 2013

- Met With:
    - Michael Welsh - Country Director/Chief of party
    - Andrew Mlewa - Deputy Chief of Party/Director of Programs
    - Richard Nsakanya - Senior Advisor Capacity Building

Collaboration

- A lot of collaboration with ZISSP under SMGL in Mansa - in fact we have had intense interaction.
- Have been working together with ZISS on an initiative were they are jointly building a stronger response for GRZ on FP by engaging in discussions with MOH and the USG partners
- ZISSP participates on the FP TWG and we have together been pushing for provision of community based injectable FP and ZISSP has been technical lead in enhancing this policy
- Collaborate with ZISSP on HIV , where the SMAGS increase access by talking about PMTCT, HIV prevention etc, and mentorship on HIV related gaps
- Collaborate during PA and TSS/QI/mentorship visits - conduct these visits jointly with the ZISSP seconded CCS
- Collaborate on ZMLA-share same trainers and use same mentors trained by either ZPCT or ZISSP
- ZISSP coordinates the quarterly stakeholder meeting with ZPCT II participates
- Participates on the human resources technical working group
- We have seen ZISSP sending seconded staff to participate in national ZPCT II planning meeting - The staff provided valuable technical input.
- Like ZISSP, ZPCT II also works with NHCs and we ensure there is not duplication of efforts - NHC activities are health related include HIV/AIDS awareness

View on key Challenges

- PMO/DMO report limited resources – vehicle, money, staff – challenging service provision.
- Partner disparities in allowance figures – harmonizing to GRZ rate based on MOH circular.
- Shared misery re: contract being too restrictive – adjustment to contract with each change.

What ZISSP can do in remaining Period?

- Help GRZ to come up with a detailed costed implementation plan – if not done ZISSP should focus on this

Positions of Seconded Staff Building Capacity?

- Clinical care joint planning
- Support stakeholder meetings
- Generally collaboration is Good

Country Ownership

- ZPCT II is at the phase of looking at how to measure country ownership. It is a process that requires continued engagement on commitment of resources, and should be an agreement

made or planned from onset of the program and holding each other accountable throughout LOP.

- The APAS training by ZISSP is a good approach for Staff to hold GRZ accountable since staff develops individual objectives and GRZ has to provide to staff what is required to do their jobs.

23rd May, 2013

Consultation with the James McAuley – USA Centres for Disease Control (CDC) co-Coordinator for the Saving Mothers Giving Lives (SMGL) Programme

Present

1. James McAuley
2. Kumbutso Dzekedzeke

Place: USA Centres for Disease Control Offices in Lusaka

What is SMGL

It is a programme initiated by the USA State Department to inspire and lead in reducing maternal mortality. This is reflected in its lofty goal of reducing the maternal mortality in half within 12 months from the start of the programme. But then again, what causes maternal mortality most of the time is pretty much known but the let-down comes when implementing the measures.

In Zambia the SMGL programme is coordinated by USAID and CDC. All US Government programmes involved in Maternal and Neonatal Child Health are part of the SMGL.

There are five major US Government units involved in the SMGL namely;

1. The Department of Defense;
2. The Centres for Disease Control (CDC);
3. The Peace Corps;
4. The USAID; and
5. PEPFAR.

The implementation role is shared between the CDC and USAID. These two agencies have 19 implementing partners among them in the four pilot districts – Kalomo in Southern Province, Nyimba and Lundazi in Eastern Province and Mansa in Luapula Province.

SMGL Strategy

The central strategy for the SMGL programme is to improve the conditions under which pregnant women delivery since this is where most of the maternal mortality occurs. This would be done by getting the pregnant women to deliver in health facilities under skilled health workers. So health facilities are being transformed to give pregnant women a memorable delivery experience and first few hours of the baby's life with the mother.

In this regard, a baseline assessment was conducted in the 121 health facilities in the pilot districts to establish their readiness in terms of skilled staff for making deliveries, the state of equipment and the

availability of equipment. Improvements have been made by the partners where deficiencies were noted. For example CDC recruited 18 mid-wives in Kalomo through it support to Boston University/ ZCHARD. The partners have implemented many interventions. They have established SMAGS, trained health providers in EmNOC provided equipment and many other interventions which will attract pregnant women and their associates to the health facilities. If health facilities are in a poor state with no trained personnel and equipment and supplies, pregnant women would not come to deliver in the health facilities.

Although maternal deaths would include direct and indirect deaths to mothers up to six months after delivery, the SMGL programme has little to offer after the delivery of the child. There are not many programme interventions after the baby is born. It is expected that other interventions in health facilities and the routine services offered in the health facilities would cater for the mother and child up to six months after birth.

Monitoring and Evaluation of the SMGL

I suggested to him that the method they are using to track the trend in maternal mortality has a lot of uncertainties.

In the first place, they estimated that there were 250 maternal deaths at baseline in the four SMGL districts, Kalomo, Nyimba, Lundazi and Mansa using about 10,000 key informants. That seems disproportionately too high to have four districts (5%) out of "76 districts"– not the worst districts in Zambia, account for about 10% of the maternal deaths in Zambia estimated at 2,600 per year. Further, none of the Maternal Death Review Committees in the SMGL Districts where we travelled to indicated anything exceeding 10 maternal deaths per year (or they are not well placed to do a good job of it).

We agreed that the best way to assess the maternal mortality trend was to look at data for cohorts of pregnant women. Their idea at design stage was to use the SMARTCARE individual patient electronic file. However, the up-scaling of its coverage is not yet extensive in the SMGL districts. So they fell onto the less reliable method of conducting a cross-section key informant survey which will be repeated at end-line. That way, the level of maternal mortality can be measured by a consistent method and errors would apply to the baseline and end-line surveys so that the discerned trend would indicate the level of success.

I pointed out to him that an improvement in variables for the SMAG registers and ensuring complete coverage of the population of the pregnant women in the SMAG communities by say providing enough bicycles to the SMAGs would be a much better way of monitoring maternal mortality since all the index cases would be verifiable from the registers as in the actual woman that died rather than just the statistics from the retrospective cross-sectional baseline and end-line surveys. He said that unfortunately, the SMGL partnerships cannot saturate the pilot districts with SMAGs. Among all the partners, only selected facilities catchment areas would have SMAGs introduced.

KII with Christina Wakefield
Technical Director, Communication Support for Health
Interviewers: Jean Capps and Beatrice C.

CSH activities are at the national level and are guided by funding streams, but none of the partners received extra money for SMGL activities. They work with SMAGs in the SMGL districts where ZISSP is also working with them. They have activities in SM, RH, HIV/AIDS, malaria and nutrition. ZISSP works in BCC and IEC at the Provincial, District and community level and collaborates with CSH for national level activities.

Their "Mother's Alive" is a CSH program as is "Safe Love". Mother's Alive promotes LLIN use, IPT, Nutrition, ANC. IRS is not included. They did formative research in malaria in 8 districts working through subgrants and the NMCC. They get input on content from stakeholders.

When asked about materials primarily in English, she said "there has been formative research that says they are effective."

They are also involved in promoting the roll out of the "1000 days" strategy for nutrition working with the NFNC.

Their major contacts with ZISSP are through Mary Kaoma and Nathalie Nugala. Initially, relations with the BCC focal persons were not strong, but they have improved.

NMCC Meeting 041813
Dr. Chibesa S. Wamulume, Case Management Officer, acting for director Case Management Office and Acting NMCC director for today.
NMCC currently under Public Health Directorate—will become Directorate of Disease Surveillance, Control and Research. She is not sure if they are moving to MCDMCH or their correlation with the new ministry. IEC/BCC has gone to MCDMCH on paper. So will IRS, which is currently under TB!

She joined NMCC in November 2010. The NMCC provides national leadership in Case Management, Integrated Vector Management (IRS, LLIN), Epidemiologist (already transferred to MCDMCH), Entomologists, chief parasitologist.

Case management: until 2010 was filled by a partner until a huge gap occurred in 2010 with no donor. Now MOH has made ACTs a line item in the budget. Still not enough but better. S/P is also now in the MOH budget. Still isn't enough even with 24 million Kw support. GRZ has actually made orders. DFID and PMI continue to cover ACTs, RDTs, Quinine, S/P. Peter Mara PS pushed to get anti-malarial drugs including 14 million for SP. You can find this in the "Yellow Book". "We will fund Directorate of Clinical Care and Support Services." Very high government commitment to procuring sufficient amounts of drugs.

NMCC Partners are: ZISSP, MACEPA, JSI/Deliver, AKROS, GF (Nets, ACTs, RDTs-UNDP PR); WHO technical advisor.

NMCC does policy and selects drugs for MIP, but MIP is at MOH RH which has moved to MCDMCH, so has FANC.

Technical Working Groups associated with NMCC: Case Management, Safe Motherhood, IRS, ITN, IEC (ZISSP support), M&E Malaria,

HW compliance is remains a problem. ZISSP helped with guidelines and refresher courses for Clinical Officers, Nurses, Lab techs, Pharmacists in Chongwe. Dr. Peter Mumba. ZISSP helped disseminate clinical guidelines for NMCC with help from their Clinical Care Specialists. The also printed treatment guidelines. Chongwe participants had never been to HRH courses, so they had the same HRH issues after training. She recommends they have more strengthening in counseling skills so they can learn to resist pressure to give antimalarials when there isn't any malaria. Prevalence in Lusaka Province is low, but ACT use is still high. If they use the Management Information System to look at:

- Number tested
- Number positive
- Number treated
- Drug given

That could be used to improve quality of case management and keep improper use of ACTs down. Logistics management is still a problem. (Is this part of ZMLA training?)
This year's Malaria Day will focus on cross-border initiatives with Zimbabwe, Angola and Mozambique in areas where they think they can eliminate malaria (prevalence is low).

IRS spraying involving ZISSP caused a lot of problems last year. ZISSP is not seen "as capable" in IRS. NMCC received a lot of complaints from the districts over payments to sprayers. Spraying stopped completely in some areas. IRS supervision was week in terms of local supervision. "Payment for IRS was a disaster." She recommends we followup with Chadwick Sikala the IRS supervisor (he was not there the day we visited) from NMCC for more details.

KII with Planned Parenthood of Zambia (PPAZ)
Director of Programs and Project Coordinator
Interviewers: Jean Capps and Deborah McSmith

PPAZ provides two ZISSP staff members seconded to GRZ. One is the ARH based at ZISS and the other splits her time between MCDMCH and ZISSP.

Major activities are:

1) providing the training and monitoring for LTFP
2) CBD training in certain target districts were TFR is high and accessibility to services is low. Decisions are made in Lusaka.
3) Adolescent Reproductive Health (ARH) with ZISSP and GRZ document including:
    - ARH Strategic Plan and Launch
    - ARH Communications (will be finalized soon)
    - ARH Health Communications Strategy
    - Peer Education Training Manual

Some of the work is done through the RH TWG (ZISSP is the major supporter) specifically in youth friendly services. They also work on Adolescent Health TWG.

4) Trainings for Peer Educators and Health Workers. Doing a pilot in Nakonde district. Expansion would depend on the GRZ and resources.

PPAZ working in 38 districts nationally and see their activities as strengthening both the MOH and MCDMCH through a broad range of community volunteers. They do not include LAM in their FP method mix but have supplies of Jadelle that could help with the LTFP supplies.

They have not been asked to be involved in looking at technical aspects of FP within ZISSP, but could do it if they were asked.

KII with Hilda Wina, ZISSP RH Specialist and Seconded Staff to MCDMCH

Her role now includes Safe Motherhood. She is also preparing post-training follow up for 26 CBDs. CBD trainer retired from PPAZ and she has been assigned that task as well. There is no HIV focal person. The TL for MCH was also covering that position. She covers FP and RH.

There is one trainer in Eastern Province and another in Northern province. Health center staff are also trained in FP. Serenje CBD training was also done. They have trained 200 CBDs in 11 districts, but don't cover the whole districts. Tried to involve the whole district with a health facility and a HW to supervise. The supervisor should go to the community on a monthly basis and observe CBDs and review their records. We are supposed to be doing quarterly supportive supervision.

CBDs provide oral pills and condoms. CBDs are also supported by Marie Stopes and JHPIEGO in addition to PPAZ. They have also organized on meeting on LTFP training and on Adolescent Reproductive Health Trainers. They also do mentorship of trained health providers trained in LTFP with the idea to train them as mentor and then have them become mentors to providers.

FP content in SMAG is more like an overview. She thinks they could be trained to be CBDs. Data collection needs to be improved overall to know how CBDs are performing.

DFID is supporting Scale up for FP and helping with commodities procurement. ZPCT2 is also a member of the FP TWG.

There are misconceptions in the public about IUDs. Providers need to sensitize women about them to provide informed choice. CBDs are sensitizing about FP (injectable).

Potential solutions to FP challenges:
Inform stakeholders about problems (supplies, misconceptions, etc.) Include Medical Stores on FP TWG. LTFP trainees should be selected from those who are already providing short term FP methods, preferably a midwife, CO or doctors.

There is no LOP plan in FP in ZISSP. Quarterly review meetings cover planning for the next year. The Ministry starts their annual plan about now (May).

KII with Dr. Masuka Musamali
FP/MNCH Advisor USAID

She has worked at USAID for 2 years. Before that she worked with male circumcision with FHI. She also worked in RH with HSSP. She is activity manager of a program that ends next year. She has been involved with SMGL. ZISSP is also in Mansa, Kaloma, Nyimba and Lundazi working with other USG partners. Government is standardizing the curriculum.

There is a newborn task team that includes Safe the Children working on Essential Newborn Care. They now know where NB care belongs.

ZISSP: Clinical Care Specialist is now being adopted by government. ZISSP has technical people but the government needs an EmONC specialist of their own.

Guidelines: They are adapting Family Planning Standardized for HW, CBD curriculum,

KII UNICEF
Jean C. and Beatrice C.
Dr. Nilda R. Lambo, Chief, Health and Nutrition
Givas Kalangu, Communications for Health Development Officer
Sitai Maswenyehi, HIV/AIDs (PMTCT) Specialist

UNICEF commented on the MCDMCH strategic plan and found it to be weak. Malaria is also increasing and child health is currently overwhelmed.

Their involvement with ZISSP is primarily through PMTCT and Safe Motherhood. They think ZISSP can contribute a lot to national dialogue on SMAGS, including selection criteria and lessons learned from the basic training of SMAGS. (UNICEF has provided funding for some SMAGs in non-ZISSP areas but those have finished.).

CHA training, students did a satisfaction study. There was a recommendation to learn lessons from first cohort. DFID is supporting the 1000 days strategy. Most high level discussions take place at the ICC but the last one was poorly attended. The MCDMCH needs technical support from a senior level advisor seasoned in strong HSS and Policy. The PS doesn't see public health implications.

PMTCT in Zambia is not doing well. Although 98% of pregnant get tested. CD4 counts will be abolished and soon 500 Health centers will start HAART with pregnant women with ARVs prescribed by nurses. Needs to be well managed. There are concerns about toxicity of some of the drugs. In Prevention ARH and FP are largely supported by ZISSP. There will be Clinical ART services. In Zambia, 16.9% of pregnant women test positive for HIV and 61% get started on ARVs but only 28% of HIV exposed infants get tested and most are lost to follow up after the birth.
But "we don't really know what ZISSP is doing. Mentorship is important. We don't see them at the ICC, but we aren't sure about USAID.

KII Interview with JSI/Deliver

Spoke with Sr. Pharmacist and M&E managers

The purpose of the interview was to get a perspective in drug supplies and logistics because that is a factor in ZISSP's ability to impact on HSS, and not part of ZISSP's mandate.
ELMIS is currently on hold. mLIP is a "pull" system. "Kits" are the old system and go to the districts. hey assist with stocking the districts (but not the entire country) and are based on CSO population estimates.. Said they do not order based on consumption patterns. The term "Central Medical Stores" is no longer used, it is Medical Stores Limited and Crown Agents have been working there for several years.

There are problems with drug procurements, regardless of who is paying for it. They are no surprised that the team found stockouts of several drugs including ACTs, zinc, Vitamin A and mebendazole. There is currently only 38% fill rate of essential drugs in the Central Medical Stores (MSL). eLMIS is supposed to strengthen the supervision system. They think there are RDTs at the national level and not sure why there were stockouts in the districts. I told them the districts attributed low stocks to not receiving their full budgeted funds.

Regardless of the weaknesses though, "we have seen vast improvements in logistics in past 6 years" and "data for decision-making is improving."

KII with Melissa A. Marx
Quality Improvement/CDC
They have a QI program working in many of the same areas as ZISSP is working. Their approaches are somewhat different and they want to coordinate with ZISSP, but their e-mails are not answered. Do not perceive ZISSP is flexible in their approach to QI. The QI training was very didactic and theoretical. It wasn't helping to get things moving. Their (CDC's) EDU program is very practical and provides training in data use. The QI program as developed has very little M&E in it, but there are GRZ indicators. ZISSP doesn't share their curriculum and that isn't cost-effective if there is duplication of effort and costs.

KII Sangita Patel, Health Team Leader
USAID Zambia
She queried the operational definition of HSS and Capacity Building? We reviewed the ZISSP results framework. "We are looking at the WHO definition and also trying to increase country ownership. What are ZISSP's benchmarks relative to what they need to report on (e.g. GHI, PEPFAR, SMGL, MNCH). Big ticket funding doesn't lend itself to this type of information. HSS for capacity building was decentralized in the MCDMCH. "They can only do so much." She would like to have more information on sustainability and lack of good M&E systems makes this difficult.

What has the systems strengthening done to advance FP with such high TFR? What about malnutrition? Stunting has not decreased since 1992. Have we supported integrated systems to deal with these things? She likes NHA mapping but those are "baby steps" related to what is needed, but there isn't enough analysis about what is. She doesn't see the continuum that links the pieces together. To what has seconding staff to the GRZ built capacity to do these things? Are we putting bandaids on the problems?

KII with William Kanawaka
COTR for ZISSP, USAID Zambia
His roles include 1) major technical direction 2) monitors the project 3) Reviews invoices for the project prior to USAID paying them. He goes to the field quarterly with the M&E advisor and does the DQA process. Regs say this has to be done at least once every 3 years. This was done for malaria and child health last year. Child health data depends on the GRA HMIS. Data is not available in a timely manner and not complete.

A "number of partners" are "looking at the HMIS". The MOH themselves are not comfortable with quality of HMIS data. The HMIS is far behind. MOH has to look at HMIS, analyze and certify it. ZISSP's provincial MS's role is to "coach the DMOs to use statistical bulletins in their planning.

ZISSP is not involved in drug supplies. UNICEF has helped with some procurement.

ZISSP's challenges:

- Turnover of technical staff
- Increased Daily Subsistence Allowance (DSA) has increased training costs.
- Training TOT national to provincial to District level. Trainers are occupied with other jobs.
- No major changes in SOW but number of IRS districts has changed
- ZISSP pays for training and monitoring IRS. Now ZISSP pays NMCC. The IRS TWG know they are not doing yearly GPS per protocol (actually it is policy to do every 3 years).
- ZHWRS is a carry-over from HSSP. They would like to know what other TA is needed. The responsibility will change over to the new ministry and not sure what will happen
- He asked questions about QI be directed to Victoria at ZISSP
- Task 4 involves integration and coordination of tasks.

KII with DFID Health Manager Meena Gandhi
DFID provided 22 million pounds of malaria funding to Zambia from 2011-2015 to support LLINs, ACTs, RDTs and collaborates with PMI and JSI/Deliver.

Also involved in HRH including the CHA program. CHAI is the lead agency. They are a paid cadre and the government has to buy in. Supervision is a problem with the CHAs.

They are also involved in biomedical equipment. This is ending. They did an audit and only 50% of equipment they provided was still working. Crown Agents is involved in this.

The corruption scandal put an end to pooled funds. There are big gaps in MNCH.

ZISSP's support to HR TWG is good. So is their work with the FP TWG. They are also working in M&E working group. MAMAs program in six districts has ended. It was supported by DFID.
There are still issues with emergency transport.

The split between the ministries has decreased GRZ capacity to take the lead in these areas.

KII with ZISSP Office of Finance and Administration
Chubuye Kasubita, Director
Charles Makewana, Senior Finance Manager

They have three accountants, three assistant accountants, and one newly-hired grants accountant. They had asked for a grants accountant earlier in the program but Abt HQ disagreed. They recently changed their mind and they were able to hire.

Requirements to retire accounts before issuing new ones has slowed things down and there have been problems with payments. They have been given permission to have waivers to expedite the flow of funds. Budget figures show a little over 50% funds spent with 61% of project time elapsed. Do not anticipate any funding issues to complete the program.

Notes on meeting the ACNM Trainers
Jean Capps, April 20, 2013

People met: Patrice M White, CNM DrPH, Senior Technical Advisor Global Outreach
Anna Maria Specialie, Technical Advisor, Global Outreach
Mary Carpenter, Consultant, Department of Global Outreach

(See Trip Report November 2012 will not repeat information here)

We discussed data in tables in annex showing "Baseline and 6 months after training" showing consistent rise in indicators in 1)ANC 2)skilled delivery 3) Postnatal Care 4) Family Planning. Definition for FP is "attended a family planning clinic" between March and November 2012.

ACNM is different from MAMA training for SMAG (funded by UNFPA). Less didactic and more targeted to rural semi-literate or illiterate communities. Use pictures for data collection. Data gets discussed within the community and at the SMAG meetings with the Health Center personnel (who are SMAG Trainers).

ACNM curriculum does contain elements of the other interventions: HIV prevention and counseling/testing, family planning, malaria in pregnancy (IPT and nets), nutrition (breastfeeding) but not all topics in each area. Newborn care (other than warming and breastfeeding) is not specifically included. HBLSS copyright issues are just to get credit and keep the quality of the curriculum, not payment.

They do behavior change but don't think of themselves as doing BCC!

SMAGS are not groups; they are two people per zone in a health center catchment area who collectively comprise a group at a health center. Some SMAGS have formed themselves after seeing groups in nearby communities.

There are 19 USG partners in SMGL. There were some problems with the CDC TA and many of their TA have been withdrawn (didn't get into the details).

ACNM uses Cascade Training: Master Trainers at District and PMO level. Start with 16 in SMGL districts. Will expand to 24. They originally trained 115 SMAG trainers at the Health Center level. This will expand to 720 by end of July 2013. They will have trained 2000 SMAGS and figure they will reach 80,000 people with Safe Motherhood messages by July 2013. SMAG volunteers come from the community and were chosen by the community. They are linked to NHC (usually 8-10 people because NHCs were involved in selecting SMAG volunteers.

Some SMAG HC trainers have been through both the MAMA training and the ACNM training. MAMA is more didactic and probably more suitable for a health worker than a community member.

There are Pregnancy Registers that they keep. SMAGS do come to meetings at the HC and bring their registers. Data flows to HC to DIST to Provincial Nursing Officer to MCDNCH.

KII with Christina Wakefield
Technical Director, Communication Support for Health
Interviewers: Jean Capps and Beatrice C.

CSH activities are guided by funding streams, but none of the partners received extra money for SMGL activities. They work with SMAGs in the SMGL districts where ZISSP is also working with them. They have activities in SM, RH, HIV/AIDS and nutrition.

Their "Mother's Alive" is a CSH program as is "Safe Love". Mother's Alive promotes LLIN use, IPT, Nutrition, ANC. IRS is not included. They did formative research in malaria in 8

districts working through subgrants and the NMCC. They get input on content from stakeholders.

They are also involved in promoting the roll out of the "1000 days" strategy for nutrition working with the NFNC.

Their major contacts with ZISSP are through Mary Kaoma and Nathalie Nugala. Initially, relations with the BCC focal persons were not strong, but they have improved.

22 April, 2013
Interviews with government staff at Copperbelt Provincial Office

Meeting with Dr. Chandw Ng'ambe, Principal Medical Officer
Copperbelt is highest population province and their HRH situation is serious. They have problems with increased urbanization because people come here to work. This province was part of HSSP and has continued with ZISSP. They have provided tremendous support through their Seconded Staff: CS, CHC and ME specialist. They have many ZMLA participants from HRH, Financial/Accounting and Information Technology. They have provided us with a lot of updates in using the Performance Assessment Tool and this had led to performance improvements over time. Now we have a PHO PA tool.

ZMLA was especially good. He thinks they could improve the program if they provided for individualized mentorships depending on the needs of specific trainees. For instance a PMO doesn't need the same training as someone else does. He thinks he could use more mentoring in supportive supervision.

He is very enthusiastic about certain community health structures that have started with ZISSP and other donor support like the SMAGS and believes GRZ is obligated to find ways to sustain them because there are high CHW dropout rates and this can happen with SMAGs too.
Interviewees:
Kingsley Kapemfu - Acting Senior Health Information Officer
Sam Phiri - Provincial Information, Communication & Technology Officer (CDC supported)
David Mulendema - Senior Health Information Officer

Introduction

The team was not very clear about what was expected on ZISSP by the end of the project as such it was not ease to strictly stick the questionnaire as designed. Instead they were asked to comment on the activities that ZISSP has done so far and what they perceived was still needing additional support or attention. The team brought out the following highlights on each of the key components that pertain to their work and supported by ZISSP.

1. Performance Assessment

a) they have worked closely with the Management Specialist in providing input towards the revision of the tools and as such they feel the now have a part in them unlike in the past were they were only administering it, albeit all the concerns they have had before on some of its contents.
b) Feedback from MOH Hq on the revised tools was taking too long

c) There was a need for ZISSP to work with the Ministry in developing a guide for revising these tools. For example each district needed to continuously document their experiences and submit them to the province instead of waiting for many years and they just call a few people to review and provide input. This tends to leave out important observations that may have faded with time.

2. Production of Statistical Bulletins

a) Supporting districts in the province to develop a statistical bulletin for 2011 was highly valued as this activity provided a platform for: peer review of each district's status; cleaning of district datasets and the prior knowledge about the common problems in the districts before the start of the planning cycle.
b) The province however did not receive any external TA in developing the bulletin and the officer (from the provincial office) who spearheaded the activity has since retired. This casts a doubt on the capacity to develop follow-up bulletins in the absence of local capacity. ZISSP to seriously consider sharpening data analysis skills in staff to eliminate errors observed in the published version of the 2011 publication.
c) The team felt that support for this activity (from ZISSP) should be coming in the first quarter of the year for them to be timely and more useful to the planning process, as they would be produced before the launch of planning cycle.
d) There is also a need for ZISSP support the development a standard guide to aid the development of the bulletins as a way of building sustainable capacity and improving the quality of future productions.

3. Data Demand and Information Utilisation

a) ZISSP supported the province in training on "management and use of data" and this was reported in the annual report of 2011. However it was noted during the interview that the training referred to was on biased towards information technology as it covered basic computer information management (File management, security, storage, retrieval etc) and not the use of information for decision-making. This training was not guided by any framework as the decision on what to include in the training was decided upon by the "Provincial Information, Communication & Technology Officer" with the support from the ZISSP-supported MS specialist.
b) The team felt this meeting did not achieve its intentions as no follow up has been made to check on how the trainees were performing. Participation to the meeting was drawn from both technical and administrative staff at the Provincial Medical Office to improve record management and sharpen computer skills.

4. Data Quality Audits

a) This activity as reported by ZISSP in the 2011 Annual Plan was not a separate support to the districts but as an integral step in the production of the statistical bulletins.
b) The team felt that this activity is incomplete in the absence of supporting the improvement of data collection and processing at source (health facility level) – through direct support or in coordination with partners such as ZPCTII. HIV data, for example requires dedicated data entry staff in each facility – lately these facilities have been losing such staff as ZPCT scales down. This concern has been confirmed at district and facility levels by the evaluation team.
c) Individual district data have since been collected and a clearer picture of the quality of the data from the focus district will be known once the final analysis has been done.

5. Training

a) The team was of the view that in order to strengthen data management in the province, there was need to extend the mentorship concept to data management.
b) Orientation in this area has largely relied on individual/personal skills and interest and lacking in the following aspects: guidelines and procedures, policies and protocols, the role of research in directing policy.

6. Perception about the ZISSP-seconded staff

a) The role of team from ZISSP was highly appreciated as an essential part to the whole provincial staff, individually and as counterparts of GRZ staff.

7. Assessment of ZISSP-seconded staff in building capacity and in their respective areas.

a) All the staff was highly rated however, they had the following to say on each of the positions:
    - *Clinical Care Specialist* – should work closely with data management team, including the Managements specialist, in strengthening the data management component of the clinical mentoring package
    - *Management Specialist* – should work on improving the frequency and quality of quarterly review meetings that seem to slowing dying down with some institutions rarely doing them. This problem was reportedly linked to the irregular or late release of funds.
    - *Community Health Coordinator Specialist* – The felt that the officer needed to be more dynamic by devising strategies that will enhance Health Promotion in the province than just focussing on reaching out to selected communities in selected facilities and districts.

Interview with Copperbelt Provincial Nursing Officer
Part 2
Data Flow from SMAGS: is supposed to go to HF, then **to District MNCH Coordinator** to PNO to Central level. She doesn't get the reports. (Info from other sources: SMAG data flow problems were already identified. A new form was introduced in the meetings in Livingstone a few weeks ago but are not yet in use in CB).
Re: EMNOC Training:
ZISSP did training of Master Trainers at Ndole Central Hospital. Only HF staff for Luanshya and Lufwanyama were included (Elijah told me they didn't train Lufwanyama).
They also "supported" training in Focused Antenatal Care (FANC). The actual TOT trainers w ere from the MOH RH United and Lusaka Hospital. They trained health facility workers for Masaiti, Lufwanyama and Masaiti (again Elijah said they didn't train Lufwanyama).
UNICEF also trained Masaiti HF (a long time ago). Basic EMONC training in Masaiti only (4) with satellite (?) All district hospitals are supposed to be Comprehensive EMNOC centers (Maisaiti's District Hospital is under construction).

MNCH: "**IMCI is the Child Survival Clinical Care Component". They have expanded it to include HIV esp. PMTCT.** (One QI indicator involves pediatric HIV diagnosis). The integration involves, Infant Feeding, ART, Testing at 6 weeks of age (at HF). From 16 weeks of age can start on ART.
ANC at less than 20 weeks is improving. So is Skilled Delivery. She bases her statements on the Joint Annual Review that is done. Staffing has increased, including midwives (since

2012). "Newborn health overall is weak. But she doesn't think there are unreported NB deaths".
KII Provincial Nursing Office Copperbelt Province, Ndola PMO
Date: April 23, 2013

Chaswe Mwelwa, Principal Nursing Officer and MNCH focal person
Interviewers: Jean Capps and Edmund W.

She is a Nurse Midwife and has worked for the MOH for 30 years. She became a midwife in 2005. First worked in Ndola Rural DHMT. Started as a Surveillance Officer at the PMO and then became MNCH focal person.

Assistance ZISSP has provided to the province:

1) ACNM trained SMAGs in Lufwanyama District and IMCI at the HF level. They trained 79 SMAG in Luanshya and also trained in QI. In Masaiti, SMAGs were trained by PPAZ (not funded by ZISSP, but by UNICEF)
2) She has been trained as a SMAG Master Trainer by ZISSP. There are now 4 Master Trainers in the Province: 2@ the PMO (her and someone from Planning); 2 in Luanshya district (the DHMT MNCH Coordinator and one man in a health facility (we later met him). Training took place in Kabwe in April 2012. <u>There is no Provincial SMAG strategy.</u>
   Then there was training for District Health Trainers for 2 weeks in Livingstone (only Luanshya in Copperbelt has District Health Trainers now and they have trained 9 health facility staff, who in turn trained 79 SMAG (individuals). She thinks the ACNM curriculum is good. ZISSP also provided bicycles to the SMAGs (2 per zone)
3) She is also a Master Trainer for IMCI at facilities. There are a few facility trainers trained by ZISSP in Lufwanyama District.
4) ZISSP support comes in the form of a) funding and b) Follow-up training. Right after training they "support" follow-ups by trainers located in Luanshya, Ndola and from Kitwe DHMT.
5) Weaknesses in IMCI performance as of now: a) malnutrition assessments (part of IMCI) are not being done. The protocol calls for the HW to remove the clothing to examine the child. They are not doing that (also calls into question quality of assessment for ARI). b) determining the severity of newborn problems is weak. (There is a government IMCI module that includes children from age 1 day. The "old' protocol started at 2 months). She says Lufwanyama 16/17 health facilities are trained in IMCI.
6) IMCI trainings are conducted in Ndola Central Hospital Inpatient for the practicum. (They cannot be sure to get enough cases for experience in smaller hospitals or RHCs.)
   RN schools now include IMCI in their basic training. She isn't sure about clinical officers.
   She is not sure if the Clinical Care Specialist (ZISSP) and the Provincial Clinical Care Specialist are involved n IMCI. She says the DHMT in Lufwanyama "used" community IMCI (we will follow-up at our visit to Lufwanyama DHO).
7) ZISSP has been involved in Mentorship with IMCI (DHOs are doing, but what is ZISSPs role?)
8) RED Strategy: This means "reaching every district". ZISSP organized training in Kabwe on country-wide standards using WHO manual to adapt to Zambian situation in October 2012 (that late?) Mentorship checklist includes RED content. They also

did RED training in 1) Mapping catchment area of all children < 1 (did they use GIS?) 2) knowing the # of children (we saw maps and charts estimating catchment populations in Masaiti and Luanshya DHO and HF); 3) knowing amount of vaccine and 4) costs of EPI "micro-planning".

9) Sept 2012 was a "measles only" campaign supported by UNICEF to get the second dose to children. It included Vitamin A and Mebendazole.

KII with ZISSP PMO Clinical Care Specialist
Copperbelt Province Date: April 23, 2013
Dr. Oscar Malakata
Interviewer: Jean Capps

Trained as MBMS, specialty in Internal Medicine, graduated in 1998. Also pass qualifying examination to practice in U.K. Worked in Lusaka private hospital in general practice from 2006-2009, and in another private hospital in 2010. Worked in Copperbelt Province for ZPCT2 from 2010-2011 in ART services. Began with ZISSP in March 2011 in provincial clinical care services.

His role is to strengthen the quality of clinical care services working with the Provincial Clinical Care Officer. Major activities are:

1)Provincial level Mentorship Training for practitioners in various disciplines: clinicians, nurses, pharmacists, lab techs, and biomedical services. The start by Mentorship Planning using the Performance Reports, focusing on High Impact interventions: HIV/AIDS, Malaria, MNCH, FP, Diarrheal Diseases and TB (part of HIV/TB) and nutrition. (He said MNCH does IYCF). He mentioned mentorship in nutrition, but we haven't heard anything more about it since. Hemoglobin testing for anemia is part of ANC, but they don't have sufficient means to do the testing. JSI/Deliver works on commodity supplies (note working on supply and commodity breakdowns <u>is</u> in the ZISSP SOW).

There is a Mentorship Guide. The mentorship progression is Provincial Hospital – District level-Health Facility-community. He feels Community IMCI is working and they have ACT/Coartem for mild malaria. The CHC works on programs to get people to go early for treatment. Focus is on the 5 QI indicators: 1) Properly treated <u>confirmed</u> malaria cases (RDT or lab); 2) Under 5 mortality rate 3)Maternal mortality ratio 4) HIV-exposed children tested at 1 yr and 18 months 5)Proportion of ART patients retained on treatment at 12 months.

His work is focused only at 5 model Health Facilities 1) St. Joseph's Hospital (Lufwanyama) 2)Fiwale RHC (Masaiti) 3) Thomson Hospital (Luanshya) 4) Mpongwe Mission Hospital (Mpongwe, not a ZISSP focus district) and 5) Tambishi Govt Clinic (Kalalushi, not a ZISSP focus district). Selection was based on ART and PMTCT lost to follow-up (mom and baby). Biggest challenge is that there are no incentives for the CHWs (presumably to find defaulters). The 10% of the district budgets supposed to support community activities (through their participation in the Annual District Plans doesn't get there. ZPCT2 is ending in May 2014 and is already scaling down.

Problem is to strengthen, but some service problems still can't be addressed only with mentoring. RDT's (malaria) are a big problem everywhere. There is a lot of malaria in this area, but without ability to diagnose, it is treated clinically meaning ACTs run out. There

are antibiotics for Community Case management—supplies are separated out from HF stocks. Supervision is a problem; lack of staff and fuel. Even in hospitals with functioning labs, malaria treatment is still much "like witchcraft" because doctors are not following protocols. Kalaluch District Hospital was prioritized because of the high incidence of malaria there.

They meet with the District Clinical Care Teams comprised of: District Medical Officer (DMO), MNCH Coordinator, Lab, Pharmacy, TB focal person, Malaria focal person, Surveillance Officer.

They do maternal death audits to identify problems with that QI indicator.

There is no Under 5 death audit. They review newborn deaths, but there is no form. Most IMCI mentors can mentor is all aspects of IMCI.
There are no problems with ART stocks or supplies.

ZISSP also supports Quarterly Clinical Care meetings where they look at Performance Assessment Reviews and TSS mentorship. But they don't happen quarterly. Last one was September 2012 (8 months ago). [Really only happening once a year with ZISSP support]. He has seen a lot of change in intent as a result of the mentoring, however.

They are encouraging District/HF QI. 69 HW trained in Province in both ZISSP and non-ZISSP districts. TSS given to 5 districts. Luanshya never sent anyone from Thomson Hospital. DHO did not come for training. In future they will do institution-based training.

EMNOC- he was not included in ZISSP's plans for EMNOC at the Provincial level. Trainers went directly to the districts from Lusaka. He doesn't have the list of Basic and Comprehensive EMNOC centers in the Province. Health facility assessments were done at the Central Level from MOH RH and they selected the facilities. Why wasn't the CCS and CCO involved in the EMNOC activities? (I knew the Provincial Nursing Officer and MNCH Coordinator was). He didn't know.

Finally, even with much to be done he says he will visit and work with all ten districts in the province plus the two hospitals that are not in ZISSP districts. (I tried to meet with this CCO counterpart, but he was rarely in the office. I think Paul may have talked to him briefly when he was on his way out.)
KII with Provincial Nutrition Officer
Copperbelt Province Date: April 23, 2013
Grace S. Hazemba, Principal Nutritionist
Interviewers: Jean Capps and Edmond W.
Topic: ZISSP IYCF activities

ZISSP is working in IYCF in three districts, Masaiti, Luanshya and Lufwanyama. In Masaiti, they trained 24 heath workers in IYCF using Zambia Food and Nutrition guidelines. Some Health Workers are TOT trained by ZISSP in ? Kabwe in 2011. They trained 6 TOT who were then supposed to train community volunteers. There are not new nutrition groups, these community volunteers include SMAGs, TBAs, CHWs, etc. in 5 communities per health center (does not coincide with the # of "zones" per health center). She says the District's chose health centers based on level of malnutrition (this was not echoed by the District). The curriculum includes "cooking demonstrations" using locally available foods.

(The locally available nutritious foods is part of IYCF, but cooking demonstrations are not and are apparently the national program. Need to follow up with materials I left in Lusaka). The following health centers were selected for IYCF:

Fiwale RHC (also a "model facility" for QI)*
Mishikushi RHC
Chileoe
Kashiti
Kafulafutu mission
Njdeman

*This is the only facility that coincides with the list of ZISSP-supported facilities in Masaiti that was sent to us on the spreadsheet by ZISSP.

Tina (no last name given) from ZISSP, "passed through here on her way to ZISSP or MOH in Masaiti. Provincial Nutrition Officer was not involved in the planning for most of the nutrition or IYCF activities.
In Lufwanyama they did IYCF activities at the following health facilities:
St Joseph's *
Milenge
Lumpuma
Kapilninkwa
Fungulwe ("Tina organized a separate training in Nutrition and HIV there)
Mushinashi
St. Mary's
KII with ZISSP Provincial Community Health Coordinator
Copperbelt Province April 23, 2013
Wendy Nyekele
Interviewers: Jean Capps and Edmond W. (MCDMCH)

She has worked with ZISSP since the beginning of the program. Prior to ZISSP she worked in social marketing of health products for the Society for Family Health (offshoot of PSI). She was Institutional Program Manager for Social Market for Basic Health Products (condoms, OCP, LLIN, ORS. She worked with CBDs and NHCs for training in SFH subsidized products. Her background is in Commercial and Social Marketing. She had some basic household level health training.

Her role is to improve the interface between the health centers and communities and the district. She does the training herself in 1) health planning process with community leaders (NHCs and HCACs). 2) SMAG training, but she is not a SMAG Master Trainer 3) BCC – she trained CSH in BCC and trained District BCC committees and organizations including other NGOs such as World Vision, Save the Children, local councils, local radio stations, DHOs, smaller CBOs and communities.

She conducted community mapping of BCC organizations in Masaiti, Luanshya and Masaiti. CSH did one and ZISSP-JHU did the other districts.

Radio Distance Learning (RDL) groups. Only 3 groups of 10 each and only in Luanshya. She has done the training in Mpatamato Section 26 HC, Fisenge Health Care (semi-urban) and Kafubu Block Health Center (rural and this is the one we visited later). The groups have

not received their radios (expected in May) and the broadcasts have not started yet. Once started, there will be one topic a week for 26 weeks, mostly on Safe Motherhood. The broadcasts can be heard by everyone. Health centers have been oriented and program will allow for Questions to be submitted by the groups to be answered on the air.

Her counterpart is the Acting Health Promotion officer for the Province. (see separate interview).

The RDL and other BCC groups are linked with SMAGs (there is some overlap in membership). There was a baseline survey and we will do follow up. All community health coordinators were trained.

For planning she noticed in the impact of the efforts. One HCAC had power to get a delivery room added to their HC. They raised money and then looked locally for more resources. They have applied to the Constituency Fund for a grant and intend to go to the local cement companies. They will donate the labor to build it. Without the delivery room, if a woman delivers at the health center she has no privacy from the other people who are there.
Women's empowerment to take action: Yes, she feels that is happening. When they assist with forming HCAC's they try to get 50% women, with the RDL we insist on it and we get it (5 men and 5 women). In the Grants Program, one criteria for a good proposal was to see composition of women implementing the program. In Luanshya, the BCC for malaria has resulted in speeches, dramas, one on one counseling, talks at the market, national days.

Bicycles are given 2 per zone and not per individual. There are still questions about sustainability of groups, but SMAGs have said they will continue without support.

Followup interview after district/HF/Community visits: SMAGs are thought to be strong and are very active. Is there a plan for scale up? (Uncertain) Have BCC groups and SMAGs been taught in planning (requests for even more bicycles because some villages are "far"). We also heard the BCC group in Masaiti sits in the Boma waiting on resources to start working (for more than 6 months). She said the idea was they were stakeholders and would use their own resources. Wendy agreed that additional training was needed in planning and resource mobilization. She also agreed that content in Adolescent Reproductive Health needs to be added to the content of all of the community and BCC groups.

KII with Clinical Care Officer
Masaiti District Health Office, Copperbelt Province
April 24, 2013
Crispin Sankando Interviewers: Jean Capps and Amon

He is a Clinical Officer for the District Health Office.
ZISSP works in 6 out of 25 facilities, including Fiwale HC, one of the 5 "model" facilities.
They have trained 50 CHWs in IMCI in 12 out of 25 facilities. They have also trained 6/25 HCACs in planning.

Mentorship is a major activity that ZISSP has helped them with and it has helped them a lot to improve the quality of care. He has been trained to be a mentor. He helps to form a QI committee. For example, in Fiwale they were selected as a "model site" in August 2012 and

the QI committee was formed in early 2013. As a Mentor he does OJT advice while someone is assessing a patient in malaria, ART, laboratory work.

ZISSP also trained the district BCC committee in 2012. But he says the DMO has the list of topics; he doesn't know what they were.

The SMAGS in Masaiti were not trained by ZISSP. They were trained by PPAZ and supported by Global Fund and RBF (Wendy says it was UNICEF).

He goes for mentoring visits about 3 times a week (but only to a few health centers). The others do not get "mentored". He really likes the Mentoring Methodology and the focus on quality. He thinks it is really improving the quality of health services in those facilities by those health workers who are trained. (ZISSP provides the "support" to make those visits).

We were joined by the MNCH coordinator and we talked about IMCI training (the same Master Trainer-TOT methodology introduced by WHO in the late 1990's. Yet, only around 25% of health workers are trained. Same problems with rotations, HW shortages, lack of support in supplies and drugs. They both agreed that another, provincial or district centered training would be needed. The only challenge is having enough children with the clinical conditions for them to get the "hands on" experience treating a child before turned back to the health facility and "on their own". They agreed that now that IMCI is in the nursing preservice curriculum that will help. They acknowledged there may be some challenges for young, new graduate nurses that are placed in rural areas who may know more about IMCI than their superiors.

KII with Provincial Health Information Officer
Copperbelt Province
April 30, 2013 Hachimena M. Joseph, Acting Health Information Officer Interviewer: Jean Capps

He received a Diploma in Business and has a Degree from University of Zambia in Adult Education. He is currently studying for his MPH online from Walden University (just beginning). He has worked since 2009 at the District level and has been acting in his position at the PMO since 2012.

He is responsible for partnerships and relationships with stakeholders and communities and to design health messages. He is also involved in the Child Health Days two times a year (last one was September 2012, but was supposed to be held in July. There has not been one since. MCH coordinates procurement of the vaccines which cost about 70 million Kw per district. He is responsible for social mobilization and sensitization for the Child Health Days as well as transport and radio programs.

They use PA reports to determine content and we have a budget to do the programs. Three days ago (on 25 April, they did broadcasts for World Malaria Day). They shared statistics about the global situation and gave information to communities about vector control (LLIN and IRS). Net supply depends on donors for mass distribution (none lately). Now targeting pregnant women and children under 5, but they have to rely on SFH that sells nets for 10,000 KW (going rate for Permanet is 40,000-55,000.

He has worked "hand in hand" with Wendy (the ZISSP CHC) and her assistance (and experience) has "helped a lot." He is involved in the RDL and formation of the BCC committees. For the RDL and BCC committees partners were strategically identified using criteria for promoting. In Lufwanyama, Zambian News Information Service (ZANIS) was identified. In others, DATF District AIDS Task Force was selected as were churches, agricultural groups, and other NGOs. "We want to link to their networks and information channels.

SMAGS "are doing very seriously challenging work. They are working very hard to increase male involvement in SM. ZISSP has helped in three districts. Next we will have a meeting for the whole province.

"Sustaining these groups is our challenge. Even for the RDL groups, we talked to them about how they will replace the radio batteries. They decided to charge a small membership fee and pay for them with that. These are pilot programs. Criteria for a successful pilot is an increase in the indicators (evidence of data for decision making!) Scaling up SMAGs should be in next year's annual plan (provincial)"

"We would like to explore IGA to sustain these groups. He would like to see the next round of Community Grants seek to explore groups willing to take that on. I asked if that included Village Savings and Loan groups and he said "yes".

KII with Clinical Care Officer and MNCH Coordinator Part 2
Masaiti District, Copperbelt Province, April 24, 2013
Interviewers: Jean Capps and Amon

Sankondo Crispin graduated as a clinical officer in 1987. He also studied Project Management at U of Zambia and got a Diploma. He will retire in 5 years. (MOH mandatory retirement age is 55).
He is from Western Province. He transferred here in 2010 from Lufwanyama District. Angela Hlowa MNCH Coordinator has been working for the MOH for many years. She has a background as a nurse and midwife. (She is recognized as a "strong" authority on the MNCH situation).

He was trained by ZISSP in Mentorship- 5 days training in Kitwe in 2012. There were 30 participants. The Provincial Pharmacist also went and so did the Lab manager and a registered nurse from Fiwale HC. Mentorship training was more on "how to mentor" not technical updates. When asked what that meant he listed interpersonal communication, supportive supervision, organizational skills. He was on leave for the first training and he joined at the second one. He realized that he was actually already doing mentorship. He feels the training that included classroom and demonstrations with actual patients was really beneficial and relevant. He gave an example where mentoring helped:

"There was a nurse at Fiwale HC who saw a child with anemia and used the IMCI concept and discovered that the child was actually malnourished. She is now able to use the algorithm to determine the root cause of the child's problem". [He says they have IMCI booklets, but no IMCI charts on the wall as job aids.] He has the IMCI mentorship tool for

IMCI 2 months to 5 years. There is a separate one for neonates but he didn't have it with him.

There is also a Lab mentoring tool. There is also a FP tool. "Ndola Central Hospital can do implants. Midwives in the district "do not feel confident to do IUD" and patients have to go to Ndola (Masaiti District Hospital is under construction).

For Maternal Mortality, they are using RBF funds but ZISSP contributes for QI and Case Management (?). In 2012 they had 2 maternal deaths. One died in the village. By the time they decided to go to health center they couldn't get there because she waited too long. There were no SMAG there.

They do PA in Health Facilities to determine who to mentor. (There is a Request for Mentorship form that someone can use to request help, but he didn't mention it.) HW mentorship, they say the HW who has been mentored is performing better. He says the mentorship is a more holistic approach to patient.

He is now applying mentorship to other non-ZISSP focus health activities (on his own). He just used it for STIs.

Sustainability: Now the district will budget funds for mentoring as part of the National Health Plan. He says ZISSP's plans to do mentorship in model sites will be expanded to be "QI in Action" to other sites. (Not sure of my notes, but he mentions something about 40 mentors. ?? planned??) Some mentors are nurses but their training is different from clinical officers. In Fiwale, they have Technical Support for cross-cutting training. Mentorship allows for skills transfer (task shifting is now an MOH emphasis). They use the twice yearly PA reviews and the HMIS as the basis for planning the mentoring. (evidence of data for decision-making).
Barriers: No RDTs since end of December (malaria "seasons" extends until March). FANC is included, so is IYCF at health centers. The Ministry is doing cascade training on FANC (not ZISSP here).99

ZISSP trained HCACs at HF.

1) Trained some and reactivated some dormant ones
2) Planning capacity is better and their roles are stronger. More focused now on what they can do.

For the future: Need more mentors in pharmacy, information officers, PMTCT, TB, mental health. This is emerging from the QI committees. Need more tech support for in-depth mentoring issues.

ZHWRS effectiveness: Some areas were left out but it has attracted some good people. The Masaiti (acting) DMO is on the scheme. Many were recruited for Masaiti District Hospital which hasn't opened up yet. Some were disappointed and left, but others are placed throughout the district. Once the hospital opens, it is assumed they will leave.

Background on recent HW salary increase. The "100% increase" in salary that was reported was misleading. (He is an officer in the national Clinical Officers Association). Many of the increases were in some parts of HRH, but not the health workers themselves.

Clinical officers, nurses, midwives may have already been higher on the salary scale and not eligible for the full increase (some only got 4%).

ZISSP staff who specifically came to Masaiti. Child Health Support Promoters (who were they?)

Wendy (the ZISSP Provincial CHC) who taught planning to the HCACs, (he gave example of result that Wendy gave about mobilizing local resources and the Constituents Development Plan application (applying for 35,000 kw, old or new KW?) for construction. The DHO will provide the specifications for the construction.

IYCF: ZISSP trained HW who do monthly growth monitoring when mother brings child for GM. They do cooking demos using locally available foods. The volunteers do follow up of children who "are not doing well". Deworming is offered (that is part of IYCF) but that is not strong due to stockouts of mebendazole. Sometimes they get some from CARE.

Malaria:

There are still some malaria agents left over from CHAZ in the communities. Only 5/23 HF in the districts have labs and there are no RDTs. So malaria cannot be confirmed and fever is treated clinically.

EmnOC: ZISSP trained midwives and nurses at Kitwe Central Hospital. There are supposed to be 10/25 facilities as Basic EmnOC Centers. They got some equipment after the training (delivery beds, suction machine, vacuum aspirator. The rest of the equipment (D&C equipment) is supposed to be coming from Central Medical Stores. When Masaiti Hospital opens, it is supposed to be a Comprehensive EmnOC center. They refer cases to CEmnOC centers in other districs including Ndola. ZISSP is providing funds for mentoring support in EmnOC.

They helped with the RED strategy at district level. They trained 15 -18 staff. Now they can submit the microplan, monthly schedule, vaccine supply requests and do annual performance assessment. Challenges in immunization in Masaiti district: seasonal difference, geographical challenges, staffing problems, transport, poor cold chain equipment. 5/25 do not have cold chain equipment. We know we need to add money to the budget for fridge maintenance. Now we have submitted to MCDMCH for cost-share for new fridges.

Key Informant Interview Enrolled Nurse and IYCF Focal Person – Fiwale Rural Health Center
Masaiti District, Copperbelt Province
Date: April 25, 2013 Name: Florida Dabali, EN Interviewer: Jean Capps

She has a diploma as an Enrolled Nurse and also in Counseling. She is a trainer in psychosocial things and in IYCF. She is also the nurse in HIV/AIDS and follows up HIV patients and links to the care and prevention teams. She has responsibilities in communities for 8 care and prevention teams for HBC in 3 or 4 zones. They have malaria, TB and OVC activities. (Supported by CHAZ). She had just come off of night duty in patient and she also has rotations in OPD. She does maternity care and does deliveries. PPAZ built a mother's waiting house and it is used. PPAZ gives them a "pack" if they come to the facility. They are seeing more skilled deliveries and have an ambulance to refer to hospital in Ndola if necessary. Quality of care in delivery has improved (ZISSP did EMNOC training for some

personnel here). "We are working as a team." (ZISSP has done mentoring here through the District CO).

ZISSP training "has made a difference. IYCF in the context of HIV. They got IYCF training for health workers (impacts MNCH care) and IYCF for communities. "We looked at existing groups such as GMP and selected some. We attended a ZISSP IYCF TOT in Kabwe and in Masaiti we did a training for volunteers in the boma. We have 5 IYCF volunteers. 3 women and 2 men. 4 are active (one had a baby) But "we need to scale up" with facility based training. Florida proposed to include grandmothers (evidence based) but they didn't do it. "This was a mistake". "IEC has to reach the home."

They have some supplemental staffing now due to HW recruited for the new District Hospital that hasn't opened yet. When it opens, they will go.

Florida participates in 14 outreaches per months for community GMP and vaccines. This is paid out of the HC running costs. She also meets with NHCs. Three CHWs were trained in both IYCF and Iccm. Any outreach they conduct includes FP. PPAZ works with CBOs for CBDs

She feels that yes, women have become empowered through ZISSP programs and others (PPAZ and CHAZ). (The SMAGs around this facility were not trained by ZISSP, but by PPAZ using UNICEF funds. "Women are more empowered, have to increase the role played by men. But women are pretty vocal here."

Since IMCI training has resulted in reduced anemia in children due to earlier care seeking for children.

For the IYCF training, they are collecting information using the picture report forms. She reviews them and compiles the data and gives it to the HC "In Charge". At one point, she was coordinating the data for the IYCF groups in all 5 facilities but she stopped because she didn't have transport. It wasn't possible to get reports from all of them to the MCH coordinator in Masaiti. But she has seen a decrease in severe malnutrition. There are cases, but they are reduced. There is an acting nutritionist at the HC, but he was attending a funeral they day we visited.

KII Malaria Focal Person
Luanshya DHMT, Copperbelt Province
(Did not use the Malaria tools because most of the questions didn't apply)

Name of Focal Person: Mr. Francis Matoka
April 29, 2013
Interviewer: Jean Capps

He has been an EHT since 2004. His role is to coordinate malaria activities in the district. But when pressed if that meant all 4 malaria interventions, he said "no, just IRS and LLIN". ZISSP was training sprayers and spraying in Luanshya District until 2010 but is no longer doing it (I am pretty sure this was one of those "gap" districts KP told us about.)

In 2010 he was trained in GIS by ZISSP and they produced maps using a software for laptops called "GRASS". He is now competent to use it.

For background he said Copperbelt has experience with IRS through the mining companies. This is something that other areas of the country didn't have.

For the last spraying season (that lasted from October to March due to "delays", they targeted 85% of the population (total was 25,500) and they reached 93% of their goals. The gap is due to "refusals, lockouts, no body home, funerals, or newborn baby in home". Another challenge is the number of new structures that are built between seasons. They do go back and try more than once. The 85% is based on the GIS that was done in December 2011 and again in February 2013.

They originally had 4 supervisors (not sure if ZISSP through NMCC is involved), then in 2011 they added 4 more (8), now they have added three more for a total of 11 supervisors. Each 5 supervisors has one coordinator. There is one supervisor for 10 IRS sprayers. They train and supervise the sprayers. Trained sprayers can only serve for 2 years. In the third year they are replaced. It is the NHC who selects the new sprayers. They receive 40 Kw for 40 days.
Criteria for selection as sprayer (guidelines):

1. Age 21 -35 years
2. Completed grade 9 or higher
3. Weight > 50 kg
4. Not pregnant or breastfeeding
5. SADC guidelines say at least 15% should be female. His experience is that women are capable. When a male sprayer is dismissed "for misbehaving", he tries to replace them with a woman. Much of their area is peri-urban so neighborhoods are not hard to reach (in general). Of 40 sprayers in the 2012-13 season, 22 (>50%) were female.
6. Data: Every Friday the sprayers give data to the supervisor who sends it to the coordinators who send it directly to MOH/NMCC copy to PMO and Chief Environmental Officer. IRS sprayers are supposed to view and collect data on the number of LLINs in the house and how many they observe are hanging. When I asked "Of the houses sprayed in this past season, what was the percentage of houses with a LLIN?" He did not know and referred me to the District Information Officer. When I asked him whether the incidence of malaria had been going down in Luanshya District, he referred me to the Information Officer.

Regarding LLINs: "In 2008 we were asked to do a (physical) survey of LLINs and estimate the number that would be needed to cover the whole district. We estimated 85,000. Until now we have never received them. At a January 2013, we had a meeting with the PMO and we were asked to give estimates again. I submitted the same number."

He was very appreciative of the help from NMCC/ZISSP. "Everything is results-based. Advice is also based on results. He feels they know what they are talking about".

[Observation not related to interview: LLIN's are available for sale in the Luanshya Boma Pick and Pay and Shoprite as well as smaller shops for 40-44 Kw for the "Permanet" and (supposedly there are cheaper nets but not known if they are insecticide impregnated). Luanshya near the Boma has mine workers (who I am told can get nets subsidized through them) and other households above the poverty level). Rural areas and some peri-urban areas have poor households. Personally, I think social marketing to the "better off" households could lower the estimates for LLIN's in this district to achieve universal coverage.)

In rural areas, Society for Family health was providing subsidized nets for sale to pregnant women and families with children under 5 years of age. As of now, it appears they are no longer in stock.]

Focus Group Discussion SMAG and RDL group Kafubu Block Rural Health Center, Luanshya District
Interviewers: Jean C, Edmond W. Amon and Paul C.
Representatives present represented all 6 zones. There are 17 represented at the meeting, 11 men and 6 women, plus 3 BCC RDL members. The SMAG was formed in August 2012. Members include 3 TBAs and one retired trained midwife. Seven are also CHWs and/or NHC members.

Their training was 5 days and was done at a local school. The RDL group consists of 10 members (7 plus 3 SMAG volunteers) and has been trained, but the broadcasts have not yet started. The purpose of the RDL group is to sensitize mothers to: 1) pregnant women should be near the facility 2) pp care after 6 days and 6 weeks 3) Maternal nutrition 4) Birth plans including money and clothing 5) pregnant women's hygiene 6) Any bleeding, go to health facility. They won't use their own radios; they need to use those provided by the project but others can listen on their own radios. They have not received the radios. No materials have been given to them in Bemba; they are all in English. The RDL will come together for 26 weeks with 26 6opics. After the 26 weeks they will get a certificate and materials to do their work. Each radio program will last 30 minutes. Afterwards they will go to communities and ask questions.

SMAGs bright orange vests with IEC messages in English were provided by ZISSP. Only one SMAG member can read English but they can all read Bemba. But when quizzed, FGD participants could recite the messages from memory.

They are very active; the evaluators observed one SM education drama conducted during GMP session. They say they got no training on how to do dramas but developed them from their own talents. They will go to the other zones and conduct them. Can't reach some far distances with the number of bicycles that they have. One member is on the HCAC and has been involved in the HF Action Plan. There is a manual, but they don't have it. They are also involved in a campaign to decrease early marriage (before 18 years) and integrate messages on early marriage into SMAG activities.
Challenges: Adolescent and unmarried pregnancies, long distances to reach communities within zone but far from HF, only get supervised on-site when they invite the HW. Supervisor went on leave and just returned. Need training in Emergency Child Birth. There is also only one MW at the health center and she is old. Sometimes she can't get the HF open in time when a woman is in labor. They currently do not make activity plans to organize shared use of the bicycles.

KII Kafulu Block RHC, Luanshya District In Charge
Interviewers: Jean Capps, Paul Chishimba, Edmond M.
Paul reviewed registers and asked about HMIS reports.
Chart on wall listing FP services available and nurse in charge elaborated and said Injectables: Noristat and Depo; OCPs: Microgynon, Microlut(?), Barrier methods: Male and female condoms, Natural FP: Standard Days Method (no beads) and LAM (she is not familiar with it). Implants and IUD are not provided here.

Catchment area is 7917 with 1752 WBCA, 1261 children ages 1 – 5 years and 314 children under one year with 380 live births, 428 expected pregnancies and 412 expect live births.

Roan Hospital Direct Entry Midwifery (DEM) School
Luanshya District
Mable Congo Kadantu, Senior Midwifery Tutor
Mulendena Magrey, Clinical Midwifery Instructor and LTFP trainee
Rosemary Ztambo, Clinical Midwifery Instructor and LTFP trainee

Roan graduates 40-42 students per year. The program started in 2008. After they graduate, they will be posted in Copperbelt, not somewhere nationally. The two clinical instructors were trained in Kabwe in August 2012. They had 5 days of theory and 9 days of practice at Kabwe Central Hospital. Trainers were from PPAZ, MOH Luanshya, and 2 Midwife mentors from Kabwe DHMT.

They got a lot of practice with Jadelle implants and IUDs but they could only practice IUDs with models because there were no clients that wanted IUDs.

22 April, 2013
Interview with government staff at Copperbelt Provincial Office

Interviewee: Musonda Kaluba - Management Specialist (ZISSP)

Introduction

The interview with the management specialist (MS) was done by firstly reviewing the contents of the 2012 ZISSP Annual Report and how that related to the activities (under the jurisdiction of the MS) in the province. This then was followed up with specific questions from the key informant interview. The respondent was very open and objective throughout the interview.

8. Strengthening staff capacity in planning and budgeting

d) Support in this area has mainly been focused in working with the PMO in preparing for planning launches, working on updates and preplanning data reviews
e) In terms of the coverage, it was learnt that up until late 2012, this activity was extended to all districts in the province but now only focusses on Luanshya, Lufwanyama and Masaiti. Her concern was that some districts that need ZISSP help in areas such data quality improvements are missing out. She gave an example where Kitwe benefited before late 2012 after having been identified as the worst in the quality of data – She however could not state the reason for the scale down
f) Other observations she made on this activity are as follows:
    - Quarterly meetings: The MS stated that these meetings would be more helpful if they were realigned with the approached highlighted through the ZMLA training
    - Revision of handbooks: The MS's observation on this activity was that lower level organs feel their inputs towards previous revisions were not taken into account much of the time.

- Planning Cycle: According to the MS, the cycle as it is now does not give enough room to the districts to use the experiences from the previous cycle in planning for the next one.
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9. Performance Assessment

a) On this, the MS had this to say: "ZISSP would do better by investing its money in already identified planning problems, than continuously looking for the same problems during performance assessments". "Technical Supportive Supervision (which is supposed to fix problems) does not provide enough time to support ailing districts.
b) PA reports are done and submitted from one level to the next one – however no system exits so that follow up activities are initiated.

10. Statistical Bulletin

a) Production of a provincial statistical bulletin is a highly appreciated activity. However, the MS felt, the exercise is very expensive, in terms of the processes and the actual printing of the copies. She therefore felt that the province should bring on bold every partner who is working in the province to contribute towards its production, so that they are also allowed to show their contribution towards improving health in given province
b) Timeliness – the bulletin (according to the MS) would be appreciated even more if produced with the first quarter of the following year. This way, it would contribute towards informing planning and still serve as a reference document.

11. Performance Management Package Support

The concept is highly appreciated. However, it requires more planning – for time and money. This is due to its cascade nature for rolling out – each next level that is orientated has more people than the next higher one. This has slowed down the process at district and facility levels.

Follow up questions from the questionnaire: "Key informant Interview with Provincial and District Staff"

1) Progress Towards Results

   Training – the following training activities were mentioned as having taken place in the province: Performance Management Package (PMP), Basic Information and Data Use (according to the MS, this training did not go according to plan follow up on the trainees has delayed – to be done once resources are available), Preplanning launches

2) Seconded staff and Capacity-building
   a) Value-addition: Community budgeting and planning has been revitalised; the team as introduced some speed in implementing some activities
   b) Bottlenecks: At times activities get slowed down because the seconded officers wait for counterparts to initiate the process as a way of building sustainability; activities are at times offloaded onto seconded staff with limited relief and; being a seconded staff, one runs a risk of blending into the government style of doing things.
   c) What seconded staff should focus on in the coming months
      i) Clinical Care – Clarity is required on the role and extent of ZISSP's role in HIV

ii) Management Specialist – Need to revisit the role of PA and its intentions; find solutions to low numbers of people trained in APAs at lower level; and find a sustainable solution to medical supplies management - quote: "this has fallen between the cracks – example being on RDT"

iii) Community Coordinator – IYCF should not be exclusively a rural intervention; Water and sanitation and its impact on health should be emphasised in messages or lobbied for.

3) General

- ✓ Allocation of resources by ZISSP to provinces should be weighed against the cost drivers in each province – eg lodging and target beneficiaries

KII Interview Senior PMO Health Education Office (CHC Counterpart)
Central Province 6 May 2013
Informant: Stabbes Mpokta
Interviewers: Jean Capps and Dorothy

He is a Clinical Officer and has a diploma in Adult Education. He is in the middle of his MPH. He has worked at the Central Province PMO for 5 years. Before that he was a Hospital Administrator of Kabwe Main Hospital, an HR office for Chibombo District and a Clinical Officer before that.

ZISSP Trainings he has participated in:

1) CHA Supervisor Training in 2012. It was done in Ndola over 5 days. He and the ZISSP CHC attended. There are 23 CHAs that have been placed in the Province. "We trained two District Supervisors (in all districts, not just ZISSP focus districts) in Kapiri. They trained EHTs or Health Promotion focal persons in each district as well as health center "in charges".
2) BCC. Training was on "How we can change behaviors in high impact interventions, for example "hand washing", "using LLINs", treating drinking water, use of condoms (for prevention of HIV/AIDS, STI, FP), early treatment of malaria, etc.) In the three ZISSP focus districts we formed District BCC Coordinating Committee. They are supposed to put <u>their</u> resources together to do the activities. The BCC Committee consists of NGOs, government ministries (including police for GBV), MCD, schools, NAC@Province, CBOs, FBOs, Community Mobilization person from ZPCT2. Their training (the HPO and CHC) were trained in Ndola and Kabwe in 2 trainings. CSH did the training. ZISSP staff were trainees.
   In Kapiri they did the BCC for 5 days in 2012. He saw how the BCC group in Serenge did an activity in Muchinka where they had low numbers of facility deliveries even with an active SMAG. Women had to come really far. The facility had only a male midwife. The BCC group called the community together (see notes from other Muchinka community groups elsewhere) and discussed the problem. The delivery room was just across from the consultation room for the OPD. There was no privacy and women did not want to go through labor there. But in the meeting they discovered that the combination of the male midwife and the poor place for delivery was keeping women from going there.
   They also discovered that there was an unused maternity waiting home on the HF grounds. No privacy was a bigger barrier than the male midwife. They fixed up the

unused maternity waiting room and within one month they saw changes in privacy. Their deliveries went from 1 to 15 per month. The BCC group promotes early ANC, institutional delivery. He doesn't know about ANC4. They are not directly involved with SMAGs.

3) Training of NHCs. ZISSP provides resources for calling meetings and provides planning books for certain centers in the 3 districts. They trained them in planning, gathering data from NHCs, malaria prevention, use of latrines and water points. They also trained them in resource mobilization. He doesn't know if they have been able to mobilized any resources yet.
4) Grantees. One grantee is in this province: The Pastor's Fellowship. They do health promotion with PLHIV. They help them to send messages on HIV, malaria and SM. He thinks they have about 2 or 3 women and about 7 men.
5) Performance Assessments. He participates in the PAs with ZISSP. "We share the same offices with them (ZISSP) and that helps."
6) ZMLA training. "This was very good. It really increased my management skills."
7) IEC materials: The only ones he could remember was distributing the "Men's Kits" (developed by the now-ended HCP project) for HIV and STI. He commented that local radio is only active in health during campaigns.

Recommendations: "If we can replicate the Muchinka BCC experience so that we can engage the districts that will lead to sustainability. ZISSP should help to scale up BCC and that will help sustain the efforts.

PMO Central Province Interviews
Met with three ZISSP seconded staff, Ms. E Mtonga, CHC, K. Kapembwa CCS; and T Muchenowa MS. Plus PMO and his staff.

PMO is recently appointed. He was DMO of Kabwe Province before this.

Felt strongly that ZISSP support was very helpful, especially with Annual Planning using PA, mentorship and helping out where there were gaps. ZISSP stepped in and did ARV training when CHAMP ended without doing it. They also helped address ability to deal with obstetric emergencies by training staff to provide anaesthesia for CS. This has saved lives.

Our problems are we are underbudgeted to do the plans we make, but if we leave something out of the plans they are rejected and sent back. So we have to put everything in, knowing that the money we have allocated is not enough to do it. Then we have to ask our partners.

ZMLA – He recently graduated and it was really good. I was supposed to be a trainer but I wasn't able.

Mentorship: Clinical Care Teams are good and he thinks it may improve service delivery but needs to be continued.

iCCM: He thinks some communities were trained

QI: Training was done in district/hospital /PMO. QI was done in the past but it had to be stopped. There are district QI communities and some at the health center level

PA and APAS: They are still using the old forms. Annual Performance now using Confidential Forms. Performance Appraisal is more interactive against workplans and is more objective.
They are restructuring assessments of management. Even JDs have come out but not fully. We are still trying to figure it out.

Systems changes: We have changed ways we do meetings. Agendas and minutes are taken consistently. We realize we have an action plan and that is the basis. They are accountable. They are now taking ideas from committees.

Community mobilization for maternal and newborn outcomes. This is fairly recent.

ZHWRS: I think that they are in Serenje but not Kapiri and Mkushi. He doesn't think it works. It is not just the money. Workers "want a good environment with power and transportation. This is from feedback he has received.

He thinks women have become more active in the community. Men have been included. Some CHAs were picked from some of them.

Vertical programs were dominant here over integrated programs. Any OPD should provide all services. We need (ourselves) to have integration and the OPD and have HIV in all of them. We caused ourselves problems with the way we did community programs.

ZISSP seconded staff give a critical eye on their programs. We need to build skills for sustainability.

One on One KII Interview
Central Province SMAG Trainer
Date: 7 May 2012
Maureen S. Siachoono, Public Health Nurse
Interviewers: Jean Capps and Dorothy

She works in several cross-cutting areas: Clinical Care, MCH and Nutrition. She is a Nurse Midwife with additional training in Community Nursing.

She is a SMAG Master Trainer trained by ACNM in HBLSS for two weeks in August 2012. ZISSP has only supported SMAG training in Serenge in Central Province. Kapiri and Mkushi SMAGs were funded by GRZ and other partners, but she doesn't know who. In the Province, there are two SMAG Master Trainers trained by ZISSP: one at the PHO (her) and one at Kabwe Hospital.)

In August 2012 they went to Livingstone and did the District Trainers all at once there and then did community-based training for 8 Health Facilities. Eleven health facilities have SMAGS (this doesn't jive with what we heard in Serenge later). At Serenge General Hospital there is also someone trained in EMNOC. In Munchinka , Chibale, Nchismishi and Kabindi, they are already trained in Mailo, Mumbachala, Chibobo and one other HF they will be trained next week. Bernard (from ZISSP) asked them to add the additional HF. ZISSP supported about ½ of health facilities to scale up. Some earlier SMAGS were trained using the MAMA curriculum. "We are going back to square one." "HBLSS (the ZISSP curriculum) is very hands-on. MAMA is just to refer". Results—"The midwife in Chibale is saying that so many (women) are coming she doesn't rest." She also thinks waiting houses would be good because women have to come so far to deliver at the HF. SMAGS started working in Sept 2012. The NHCs were already there.

Challenges:
The flow of information is weak. It goes right from the HF into the HMIS. She goest to Serenge to follow-up SMAG trainings. She has met with the SMAG members. The SMAG registers are "real eye-openers." They go "past just referral" and "contribute to saving lives". Traditional leaders and headmen gave feedback—they can see a "real cause and effect." They also feel the neighborhood and NHC are stronger. Some of them are innovative and are creating "their own books." They also talked with the SMAGS about wear and tear on the bicycles and they say that they can "work it out" to keep them repaired (talking about sustainability.

SMAG training promotes early ANC but she doesn't think it specifically promotes ANC4.

One on One KII Interview
Principal Nursing Officer and MCH Coordinator
Central Province 7 May 2013
Informant: Ms. C. Sooka
Interviewers: Jean Capps and Dorothy

She was a Nurse Tutor from 2001 – 2011. She has also graduated in Midwifery and has a Masters in Nursing, pending her thesis. She has done one EMNOC Training but she is not a SMAG trainer. "We have a number who have been trained in EMNOC who need to be followed up." She went on some follow up visits with "people from Copperbelt." There have been two LTFP trainings since she came, two were in Kabwe. She has only been in her current position for a few months.

She is not yet trained as an IMCI trainer. "It is difficult." Yes, "EHTs have been trained as IMCI supervisors. EHT's are even doing deliveries, even though they are not trained." She has seen that they need supportive supervision for it to work. They have funds from H4+ (CIDA/WHO/UNICEF/UNAIDS) to pay for retired midwives to come back to work on contract.

Responsibility for PMTCT is under Clinical Care. Problem is with spouses testing. Positive women interventions include Nevirapine, then full HAART and Nevirapine for the baby. Most EHTs are not trained in PMTCT.

ZPCT2 is working in Kapiri urban and rural, Serenge General Hospital and ART Centers and Mkushi ART centers. PMO gets most of the ARV and PMTCT data directly from them. KABWE ZPCT2 office phone numbers: 0977 8289550 (Iris) and 0962247085 (Margaret Mwanza).

ZISSP FANC: They gave some money for training and the trainers came from Lusaka. She was trained in the first of three workshops with 45 participants from Serenge, Mkushi, and Kapiri. Serenge was just trained last month (April 2013). The training includes developing Action Plans. Follow up is from Lusaka.

FANC challenges: 1) Documentation Problems 2) Stockouts of RPR, 3) Hemocues are broken 4) reagents, or strips for Urinalysis are out of stock. ZPCT2 has been trying to procure hemacues (not ZISSP). Mostly the hemacues need to be replaced but she doesn't know how it is possible.
Their Action Plans include lobbying for more budgeting for FANC and to put aside money to buy things when there are stockouts. They also need to lobby for resources to the PMO, ZPCT2; government funds cannot supply these things.

The quality of ZISSP trainings is good, but why did they reduce the number of FANC training days from 6 to 5? They were rushing to push and finish at the end.

"SMAGS have really brought positive action to our population. In facilities where there are SMAGS (in the community) we have seen increased institutional deliveries. Although she hasn't been trained in SMAGS, there has been an increase in institutional deliveries in their data.

ZMLA – she has been trained and "I really appreciate that one! It is very helpful. I have really improved in my report writing!"

Key Informant Interview
Fiwale Rural Health Center, Masaiti District ("model" QI facility)
Copperbelt Province

Name of Informant: Florida Dabali
Title: Enrolled Nurse, IYCF Focal Person
Date: April 25, 2013
Interviewer: Jean Capps

The RHC has 48 beds with 8 nurses, 3 clinical officers, 2 midwives, 1 lab tech and1EHT. There are 5 temporary staff there waiting for the Masaiti District Hospital to open including 1 Clinical Officer, 3 RNs and 1 enrolled nurse. Florida is "regular" Fiwale staff. There is a nutrition/ag person assigned to the health center, but he is at a funeral today. (Our visit also coincided with the day the bicycles were distributed to (non-ZISSP) SMAGs and a large Africa Malaria Day celebration attended by both the DMO and the District Clinical Care Officer.)

She is an enrolled nurse and also has a diploma in counseling. She is a trainer in psychosocial support and IYCF. Her usual duties include HIV/AIDS. She follows up HIV patients and links them to 8 Care and Support teams that were started in 3 or 4 zones by CHAZ. They also have malaria, TB and OVC activities. She also does regular duty assignments in the health center, including maternity care and OPD. She does deliveries. Someone who attended EMNOC training in Ndola oriented her to EMNOC. There is a midwife (in addition to the male midwife who is also the "in-charge) who works there but she is currently in Ndola. The RHC has an ambulance to transfer complicated cases.

They have a maternity waiting house built by PPAZ (not as part of ZISSP) and it is used. PPAZ gives a "pack" for the baby if the mother comes here to deliver. She is noticing an increase in skilled deliveries. They got some equipment including suction which has improved quality of newborn care. Quality of care in labor has improved because "we are working as a team and there is transfer of skills."

The health center does 14 outreaches per month that includes GMP groups and vaccinations. The IYCF volunteers are active then. Any outreach also includes FP. There are CBOs (trained by PPAZ and not by ZISSP.)

ZISSP training "has made a difference".

She was trained in IYCF by "Tina" and "The Province" and UNICEF. To select volunteers to receive IYCF "We looked at existing groups." There was a TOT in Kabwe. Then we did training of volunteers in Masaiti (Boma) for volunteers. At this facility, we trained 5 volunteers, 3 men and 2 women. Now 4 are active. There are 5 IYCF groups including other facilities in the district. She was "asked to supervise those other groups too, but I stopped doing it because I have no transport". On the first Wednesday of each month, she reviews the IYCF data forms. She compiles the data and gives it to the health center "in charge" and it gets sent to the district MCH coordinator. There is a perception that malnutrition has reduced." (How can we say the role of ZISSP IYCF training??)

She thinks the IYCF is important. Grandmothers were not targeted in the IYCF approach and "that was a mistake". "IEC has to reach the home." She sees a need to "scale up" IYCF with a "Facility-based" training approach, not just taking a few volunteers per facility to be trained in Masaiti (boma).

She was not trained in C-IMCI (but the EHT was!!) She thinks CIMCI has improved the child health situation. IYCF and CIMCI were "not parallel programs." Three CHWs were trained in both IYCF and ICCM.

She thinks that women have been empowered to access key services by increasing male involvement. "It is much more common for early care seeking and this has decreased anemia". (But the SMAGs were not trained by ZISS). "Women are pretty vocal here." "We have had CHAZ support for a lot of our community activities here."

24 April, 2013
Interview with government staff at Masaiti District Health Office

Interviewee: Jesper Musonda – Acting District Medical Officer
Golden Kangala – Human Resources Management Officer

Introduction

The interviewee was acting in the place of this place because the DMO has been out to school for some months – his full-time position is that of District Planner. The evaluation team faced some limitations on how much information he was able to provide. Although we were provided (in advance by ZISSP) with a list of facilities where ZISSP was providing some intervention, we realised when we were on the ground that there existed some minor variations. The discussion with the acting DMO therefore, started by confirming with the district office the distribution of interventions. Below is a summary of as provided by the DMO:

Facility Name	Intervention Area or Training Provided				
	HCAC	ICCM	Mentorship [119]	IYCF	BCC
Mutaba	✓	✓	✓		District Committee formed and based at the district office
Chondwe	✓	✓	✓		
Miyengwe	✓	✓	✓		
Chindondo	✓	✓	✓		
Kafulafuta GRZ	✓	✓	✓		
Kaloko	✓	✓	✓		
Kashitu		✓	✓	✓	
Mshikishi		✓	✓	✓	
Chilese		✓	✓	✓	
Fiwale		✓	✓	✓	
Kafulafuta Mission		✓	✓	✓	
Njelemani		✓	✓	✓	

It was on the basis of the information provide in the table above that Fiwale and Kafulafuta GRZ were chosen for the site visit in this district.

12. Human Resources for Health
    a) Retention of Essential Health Workers
    It was learnt from the meeting that district has a four (4) staff on retention scheme and the district could not tell whether any of these where supported by ZISSP. The district made the following observations about the scheme:

[119] All the facilities benefitted from mentorship from December 2011 to December 2012 when focus was shifted to on Model Site - Fiwale

- It is too centralised that staff have very little to contribute in managing it. Once a staff member applies to be included on the scheme – there is no formal follow up upon submitting the papers to Lusaka for processing
- If a staff member moves from a facility that is eligible, it is cumbersome for the system to suspend payment even if Lusaka has been notified about the change.
- The team recommended that there was an agent need to revise the qualification criteria – both in terms of geography and staff cadres; revise the package to include other non-financial incentives and; improve on the information flow from the districts to the national level and backwards.

b) Performance Management Package

The district benefited from ZISSP and appreciated the value of PMP and the associated Appraisal System (APAS). However the district felt the exercise was expensive, given the number of health workers that needed to be covered. It was learnt from that district the district had initially targeted to train 190 staff by April 2013 but had only managed to cover 60 of them

13. Quality Improvement and Clinical Care
    a) Although this activity was highly appreciated and noted to be adding value to supervision and service provision, the DMO felt that a deliberate plan was necessary so that this innovation could become integral components of routine activities such as Performance Assessment.
    b) The acting DMO was of the view that this component would even be stronger if a system of self-assessment was strengthened at service delivery level and linked to mentorship – this way, ownership would equally be instituted in service providers.

Follow up questions from the questionnaire: "Key informant Interview with Provincial and District Staff"

4) Progress Towards Results

   The DMO summarised ZISSPs achievements as being at 80 of what they were expected to achieve to date. This is so because of the unplanned cut-backs in the intensity of interventions at community level

5) Seconded staff and Capacity-building
    a) Value-addition: The acting DMO had this to say about seconded staff and their contribution: "*We will just miss their presence, otherwise we have gotten their concept, in that they have not been a project that just dishes out money*"
    b) What seconded staff should focus on in the coming months
        i) Clinical Care – Increase the number of sites eligible for mentorship instead of only one.
        ii) Management Specialist – When asked about the MS, the DMO had this to ask: "*What is she doing*"
        iii) Community Coordinator – Double the number of communities that should benefit from community-level planning (from 6 to 12). When asked further about the seconded officer role was, he mentioned training in malaria management, community IMCI and GMP at community level

6) General – Being in acting position, the interviewee may not have had access to all the key as expected of a chief executive of the district.

24 April, 2013
Interview with government staff at Masaiti District Health Office

Interviewee: Kasongo Benjamin (Mr) – Accounting Officer

1) Progress Towards Results

   The officer appreciated the training the district received through ZISSP support – which targeted non-financial managers. About this training, Mr Kasongo had this to say: "*We have observed changes since the training, each time you write cheques, they (signatories) asking for a bank balances against which they are signing a given cheque and finance meeting minutes. They now have a questioning mind. Knowledge has improved – before we could just dictate*".

   On the execution of the 10 per cent for community-level activities, the accounting officer felt that the 10 per cent is part of the 60 percent service delivery budget for the district. However, the fund in real-terms is paltry and is given to the facility staff as imprest. All community capital projects are managed from the district-level budget.

2) General – When he was given an opportunity to comment on what ZISSP can do better, he had this to say: "*It is important that ZISSP provides prior information on what they are supporting and how much. At times the go straight to the facility and spends funds there without the district knowing – it is difficult to know their level of support*".

24 April, 2013
Interview with the Sub grantee - COIHEP

Interviewee: Payne Mano – Programme Manager
Evelyn Nalavwe-Chipe – Deputy Programme Manager

Introduction

The interviewees are the two senior-most officials managing the sub grant. This is a BCC sub grantee covering three sections of the district: Mikomfwa, Luanshya central and Fisenge. Below is discussion the evaluation team had with the two officers:

Month of award = August 2012
Month of signing the contract = November 2012
Duration of the award = 12 months

1. Activities conducted to date

c) Orientation of the following leaders and stakeholders:
   - councillors,
   - the District AIDS Task Force,
   - the District AIDS Coordinating Agents

- representation from the District Health Office

d) Training of Community BCC Agents

Training of agents was done in two trainings of four clusters each with 25 participants: the first training targeted agents that were already active with community activities in areas where BCC was urgently needed. Targeted for training were SMAGs, Neighbourhood Health Committees, Community Health Workers, Traditional Birth Attendants, TB Adherence Supporters and Malaria Agents. Trainers were drawn from the District Health Office and Roan General Hospital, using the curriculum from ZISSP

2. The Role of BCC Agents
    a. Promoting safe motherhood in the communities
    b. Promotion of male circumcision
    c. Information on the prevention of malaria
3. Supervision – BCC agents are attached to a health facility and the facility in-charge provide daily oversight while COIHEP staff are responsible for ensuring that programme targets are met.
4. Coordination – The district BCC committee, chaired by the DACA, meet quarterly to discuss BCC activities in the district – these meeting are called by the MoH.
5. Sustainability – The sub grantee hopes to looks for alternative funding once the ZISSP resources come to an end
6. Monitoring and Evaluation – The team reported having had difficulties with the reporting forms. At the start of the project ZISSP did not provide clear direction on what to report on and in what format. Reporting forms were introduced later – by then the sub grantee had already developed their own, based on previous reporting experience. At the time of the evaluation, the team was still transferring information to the ZISSP forms.
7. Financial Management – The sub grantee is expected to submit monthly cash request. By the 22nd of each month they are expected to submit a reconciliation report for them to be eligible for the next disbursement. This, according to the sub grantee has paused a challenge because activities always spill beyond this deadline.

Important: The sub grantee was not sure when the 12 months will elapse because of the confusion arising from the two dates – August 2012 as the award date and November 2012 (when first disbursement was received) as the month of launch.

KII St. Josephs RHC
Lufwanyama District, May 2, 2013
Dr. Amisi Ngongo, physician and in-charge of RHC

Trained in QI programs by ZISSP in Kitwe in 2012. The nun who works in the lab was also trained. The QI training was very helpful. For example they are supposed to do CD4 every 6 months and repeat. Now we can follow-up patients to do CD4. After they went through registers and found 50% weren't getting their CD4. The sister did this also did it for the lab.

They did group work at Kitwe Central Hospital. They identified incomplete completion of patient registers and poor diagnostic recording such as "only STI" not the type. Drugs listed did not include dose and duration. "Trauma" only not type. This was followed by group discussion. There was no relationship from registration to the lab, to the doctors or to the pharmacy. There were also misplaced registers.

When we came back from the district we looked at the 5 QI indicators and also looked at our registers. Their child mortality showed 5 deaths in 2013. In children under one year there was one newborn asphyxia and one case of pneumonia. In children ages one year to 5 years deaths were from severe gastroenteritis and dehydration, one "immunosuppression" (HIV) and malnutrition and one severe malaria.

In QI they looked at causes of death and identified that for the pneumonia deaths they need oxygen and for asphyxiation they needed suction (machine was not working). For the malaria deaths, they came too late and they used that information to mobilize the community during outreach. The HIV+ child was from Kalalushi District. Mother was on ART and stopped. Seems there were family social problems and they were a family outside of our catchment area. We were reading the ambulance to transfer the child to Kabwe Central Hospital when he died.

QI training helped us to identify where we need to pay more attention. We can extend this program and increase activities to do more to track ARV defaulters and treatment failures. We can do more to track malnourished children, both with and without HIV.

They have also received mentorship. They send a mentorship report and discuss it with the person. He is confident in the clinical part but not sure about the score targets.

KII St. Josephs Hospital
Nurse and IYCF Trainer and MD in-charge
May 2, 2013
Cecelia Mulenga RN

She was trained as an IYCF trainer and she has trained two groups: one of 40 volunteers and one of 25, all of them in this district. ZISSP organized these trainings at health centers. World Vision and Save the Children also train but she doesn't know where. She did her trainings at St. Josephs. A topic on HIV and nutrition was also included. She did the training and she is supposed to supervise them. They are supposed to submit the forms but she hasn't received any yet. She showed a copy of the training booklet. "Here is the form in the book and they said the trainees should photocopy it, fill it out and submit it but it doesn't happen." IYCF volunteers were trained in March. Save the children also training and will followup and supervise about once a month.

Mentoring began last year. 2 Clinical Officers at St. Joseph, 2 MW and 1 nurse work here. They have supplies of RDTs.

St. Josephs does not do any FP, even natural methods. They refer clients to a government RHC. They have competence in IMCI, but they don't have the newborn IMCI algorithm.

KII Lufwanyama DHO (located in Kalalushi District)
May 2, 2013
DHO will shift to Lufwanyama soon. Just waiting for staff housing. New district hospital is being built and will open soon. It is located 56 km from Kalalushi.

Acting DMO Mwanza Nebert. He is also the CCO.
Nelsen Waitolo – PHO
Ms. Sichamba Annie – MCH Coordinator

They had not received fax from PMO saying we were coming because their fax machine was broken. They have meetings scheduled with World Bank program over the next few days.

Save the Children has supported the CHW training in iCCM, ZISSP has helped with QI training and St. Josephs is a "model" facility. There is now a QI committee. And Ceclia Mulenga, a nurse midwife has been trained as a IYCF coordinator.

There has been a great improvement in training us in things that we lacked. Before ZISSP we were not very active (silent) in nutrition. We think that every HF should have training in Infant and Young Child feeding. " We brought up to look at height. HC staff were trained, they were supposed to "orient" each other. Trainings were well organized. Students got counseling cards and we observed volunteers using them. The training was at St. Josephs.

(MNCH Coordinator) There has been training in LTFP in 7 health centers. We never used to have enough staff trained. Now we have LTFP. IUCD- we don't have instruments. Now we have made an order and we are waiting for them to arrive. This is a priority, but we do have Jadelle. She has presented this information to the DHO.

FANC has increased services, esp. screening on malaria, Hgb, HIV testing. More focus is on pregnancy.

ZHWRS – We have some supported workers in our district. He thinks it is helping to attract and retain staff. More than 2 facilities have staff that wouldn't normally have them. They are at 64% of their HRH needs. When the new district hospital opens in August 2013, it will have CEmONC care. He would like to scale up ZHWRS to other facilities.

Support from ZISSP. QI looks at stakeholders that contribute and give tech support. Plus we have the clinical mentorship for supportive supervision. For QI they give us money. They feel the fora for QI meetings with stakeholders will continue. The other things are in our mandate and we have to sustain them.

He thinks there has been increases in EBF and institutional delivery and men are taking their children for health care. "We are a vast district and very rural with HF. Our strength is in communication. We were just given CHAs. WE have 112 CHWs but only 84 are active.

RBF has contributed to better supplies. We have other stake holders suchas CCM and CHAZ. CHAS is providing RDT and ACTs. Only problem is with zinc. Last ITNs were in 2008 and they are worn out. Coverage for IRS was 86% and we need to scale up. 2 children died of malaria. One was delayed and the other we didn't recognize due to a lab error.

Coordination and Integration: ZISSP has good synergy with ZPCT2, Marie Stopes, SC, SFH (CBDs), mobile FP, LTFP (Jadelle/IUCD).

Key integration challenges:
Each stakeholder has their own "conditions" at community level. Some want to do VCT and that's all.

Provincial ZISSP support: Oscar comes and Wendy works with the PHO and they share responsibilities. We work to look at causes, and what has contributed to them. Wendy has worked will with the PHO and helping. They do get inconsistent funds, however, for their activities. Their community action plans are done with their help. Oscars TA is very strong on PA. "We use that tool." Also QI/QA is strong.

We need to do more in EmONC. Long distances to HF, especially after the district hospital is opened. Our district needs more EmONC training. RBF does training according to the numbers, which were not adequate. Where HF and S"OM MW do deliveries. They have done well with equipment last year. Facility can procure their own equipment. RBF has an office but no follow-up on the EmONCH trainees. MNCH should visit from Kitwe.

FGD with Mothers of Children under 5 years of Age
Under 5 Clinic, Mibenge RHC
Lufwanyama District, Copperbelt Province
May 3, 2013

Signed informed consent was obtained.
This HF is the only place to go and numbers of people who bring their children for child health services has increased. When polled, the majority of women had walked from one to five hours to get there this morning.

They bring children to be weighed. Services they know are available include under 5 care, malaria, FP, deliveries, ANC, referral to Kitwe if needed, PMTCT, TB, ORS + "tablet" and "teach hygiene" (wash your hands with soap.) They have clean water with bore hole wells, river. Some treat their water with chlorine, some don't. It costs between 1,500 and 2,000 kw and is available in Kalalushi (30 km away). Sometimes they bring it to the center and give it away for free. "When you use chlor you don't have abdominal pain and diarrhea."

More people are coming more often to the HF. Word has been coming to the community that they should come for delivery. The TBAs and NHCs call them. (A TBA volunteers to help the nurse at the clinic.) They get the information from the TBA and NHC for "the chairman and village head man to hold a meeting. (Two times a year). NHC and youth do a drama. There is a Mibende Youth Health Prevention Club (formerly an HIV club). Messages include:
Avoid Early Marriage, Avoid Sex Before Marriage, Child Feeding.

There are 6 IYCF volunteers in some sections. They call meetings, maybe twice so far. They give messages on cleanliness, cover the food, EBF to 6 months (BF only), then give porridge (when asked about frequency they were not sure; one said 1 time per day the maximum was 3 x). Should give sweet potato, bananas, oranges, ground nuts, rice. Community groups increase attendance at these meetings.

Challenges: HW are too few for the number of clients. They don't have an ambulance.
Yes, they are happy with services.

[At this time a man, woman and newborn baby arrived, accompanied by a TBA. The woman had given birth in the nearby village trying to get to the HF. Her husband had told her that her abd pains were food poisoning and left her at home while he brought the other children to the under 5 clinic.]

FGD with IYCF Volunteers
Mibenge RHC, Lufwanyama
There are 5 total. One stopped. Today only two could come for meeting. The group is 3 men and 2 women. The two men who came are both CHWs (not trained by ZISSP) one has been a CHW for 15 years, the other for 6 years. They were selected for IYCF training by the HF staff.

They were trained in June 2012 for 8 days at St. Joseph's hospital. Trainers came from NFNC, Lufwanyama DHMT and two from St. Josephs. They learned about promoting breastfeeding, cooking demonstrations with local foods that are acceptable and affordable. We encourage them to feed 5 x per day. (Different from what women in under 5 clinic told interviewers.)

Regarding sick children, we tell them to continue BF, use chlorine in water or boil it. They did not remember learning anything about feeding the sick child. For maternal nutrition they remembered types of foods, but were not sure about quantity or frequency.

KII with Enrolled Nurse
Mibenge RHC, Lufwanyama

Review of register showed large numbers of malaria cases even up to present (May 2013). Entries up until Feb 2013, show malaria diagnosis confirmed with RDT and treated with ACT. After mid-February that register documents clinical malaria, not confirmed and treated with Quinine. The nurse says they do not have RDTs or ACTs in the clinic at this time, but they still continue to have malaria, but presumed because they can not confirm by RDT or lab.

She was not trained in IMCI, but the other nurse who works her was and she shared the information with her. It helped a lot. She was trained in LTFP in April 2013 (last month). They do not have equipment to insert IUD and Jadelle has been ordered but not delivered. There is increased demand for FP. She has started sensitization on implants, Depo, OCPs, Male and Female Condom.

During ANC, if HIF+ we start them on ARV then refer to St. Josephs. At 6 months they do a list of RDTs. She says they completely ran out of RDTs 3 weeks ago. She has nets for pregnant women and children under 5, but those will run out soon. IRS was done in December but they still had a lot of malaria, even after the IRS.

She has 5 TBAs to work with her. They escort and help out. Teenage pregnancies are a problem. They marry them off early here, sometimes at 15 or 16, but no polygamy there. At this facility they have 1 RN, ! EN, ! MW and ! EHT to be fully staffed, but there are only 2 of them working there.

Some mothers give a cereal based drink of rice water or maze water. Deworming is with Albendazole, but only during child health week. They promote BF until two years. LAM is not emphasized in IYCF. Report forms she showed us from IYCF volunteers was the MOH form measuring anthropometry and reporting malnutrition from GMP for all children under 5, not the IYCF form. CHWs go out one day a week and as needed and work with the NHC. Nurses supervise their work.

Key Informant Interview, District Medical Officer
Serenje District, Central Province, May 9, 2013
Interviewers: Paul C. and Jean C.

He has been working her for 5 years. He left for 2 years to get his MPH.

What activities has ZISSP done in this district and what have been your experiences with them?

Clinical Care: "ZISSP helped us a lot with the Mentorship activities. They filled a gap in service delivery. We got trainings in IMCI, but we were not doing follow up and sustaining the quality of care. With their help we provide mentorship to 90% of our facilities.

Capacity Building: They helped us with revamping and retraining CHWs and community groups to do Action Plans. This is still on a "small scale: but only 4/19 facilities. They talked to Ms. Monga (ZISSP CHC). We have so many groups and types and so many different partners and types of partners." Last month we gave money to all health facilities to do the planning. This is in line with what ZISSP has been doing with us. We will follow through and make funds available to continue these activities.

SMAG Training: There have been 2 streams. First there was the MAMA's program that ended 3 months ago. It started in 2010. ZISSP has trained SMAGs in 4 (out of 29) facilities (catchment areas). So this is not even 1/3 of the facilities in the district. SMAGs were a pilot originally. We have been talking about scaling up but "these are costly trainings" and we need to know how we can sustain them. CIDA H4+UNICEF/UNFPA/WHO/UNAIDS is providing support in a 3 year program. This is targeted to the Action Plan and then we'd have to sustain it. "The mandate is to train. We have a plan to train the SMAGs. I would rather maintain the ones we have. We have to link everything with the Provincial and National Plan.

IMCI: "The Key to IMCI is supervision." He likes ZISSP's emphasis on supervision and working through existing programs. He would like to develop a sustainability plan for mentoring.

Data: "We have a lot of challenges in data quality. During performance reviews we use the data. We need to have data audits. There was one case of a newborn death due to "neonatal tetanus" in the first quarter of 2013 in a district HF and he didn't even know about it. "The issues of data ownership is not there. The data and activities are 'singing' to each other. Most of the data are under-reported.

QI/QA training:" Not much emphasis on this within the MOH. There are a lot of gray areas, including the 5 "C's". It needs to be refined. QI is very academic. I looked at the guidelines and there is a need for definitions at a practical level. For example, what are the QI elements in a labor ward?"

Bottom line: ZISSP has made strong contributions in Clinical Case Management and IMCI and we are willing to sustain them.

Focus Group Discussion, SMAG
Muchinka RHC, Serenje District, Central Province
May 9, 2013
Interviewers: Paul C. and Jean C.
The SMAG was formed in July 2012. Today there are 3 women and 3 men present, one each per zone. They have 10 zones with currently 7 women and 13 men. Some zones have only men because they couldn't get women volunteers.

Activities: The go out into the zone one day per week. The community decides which zone they will visit. They involve the headmen and make plans to visit in the afternoon. They meet with mothers and fathers. They have been successful in getting the fathers to attend. The community organizes refreshments and decides on the roles and responsibilities. They also invite the breastfeeding groups to join. (There are some breastfeeding groups that are active.) One males is involved in a BF group and there are also 2 people from the NHC involved.

They use "that book (HBLSS) for facilitation." And "they have a written plan". They also have a SMAG coordinator for the RHC, a man, and he speaks English. He showed us a very good written Action Plan. They also take minutes and keep a record. They use the Action Cards (seen) when they go to the field.

For newborn care at the home, we tell the family to bring the baby to the clinic for newborn care. We use the bicycle to help transport them. They teach about post-natal care The "chair reminds me with a cell phone". Another program is doing SMS (by another project).

Challenges:

The zones are big, between 12 km to 20 km from the health center. They sensitize the men and encourage with their wives to the health center. The SMAG volunteer also accompanies them.

They received T shirts, vests, ID cards, books, training materials. People who own cars will sometimes pick them up and take them to communities. Communities come to them and ask questions.

Antenatal advice that they give includes, hygiene, using LLINs, eating good food, get blood tested, injections, deliver at the health facility and come to the SMAG for assistance. They also promote FP. Males explained in their culture, women are responsible for FP. SMAGs have changed that opinion.

They have a log book (seen) where 4 out of 7 deliveries took place at health facilities. "Before SMAG they were asked to give birth in a small room by a male midwife." They would refuse. After sensitizing the males the women started to come. This was done through involving the headmen and also ZISSP and district brought a group that included the church people and a policemen (this was the BCC committee).

Re: bicycles. We were told "this is your (the communities) bicycle. You need to take care of it." For sustainability. We have asked for donations from the community to sustain our work. In some cases we got a chick or some sweet potatoes. (One SMAG volunteers said she asked for money and "collected 5,000 Kw each from 4 people". "We will continue to do our work. We are saving many lives. This is different from other kinds of groups. We have seen the pluses and minuses of outside assistance. This program emphasized sustainability from the beginning and the need for community support. The community supports us, so we will continue. We learned so many things, and now we know what we are supposed to do. Since the SMAG no mothers or babies have died. Before, they did die. Monitoring visits serve to motivate them, (including the visit from the evaluators.)"

Training took place in Muchinka Primary School in July 2012 by the district and health workers. They liked the training. They also think it helps HIV because couples are going for testing.

Women's empowerment in health: Before SMAG, women would wait until 6 months pregnant before going for ANC. Now they come at 3 months. Now they can get assistance from female SMAGs to go earlier. They tell women to go for ANC at least 6 times.

Unmarried pregnant women are a problem but they will also help them. Some are as young as 12-14 years old. They had a woman who was 25 years old, unmarried and pregnant. She was an orphan and had not family.

IYCF Volunteer KII
Muchinka RHC, Serenje District, Central Province
May 9, 2013
Interviewer: Jean Capps

She is also a NHC member and was trained last September 2012.
She came to a lot of meetings and was selected as an IYCF volunteer by the HF because she was active in these meetings. She was promised IYCF counseling cards after the training but she hasn't received them. "They didn't have enough for everyone who was trained."
She does her work only at the HF and does not go into the community. She give's talks during the monthly under 5 clinics when mothers bring their children to be weighted. This takes place only on the last Friday of the month. She was told to come then "because that is when a lot of people come to the clinic."

She doesn't make any reports. The in-charge has emphasized the need to write reports but she really doesn't know what she is supposed to write.

They only have GMP here at the RHC, there are no outreach activities. She has not received any follow up visits after her training. She did a cooking demonstration one time using locally available food.

She is 6 ½ months pregnant with her 5th child. She says she will start up again 2 months after the baby is born. She was told to form a support group but she hasn't done it yet.

NHC/HCAC Focus Group Discussion
Muchinka RHC, Serenje District
May 9 2013

Interviewer: Jean Capps

The HCAC represents 10 health posts with 10 NHC members each.
They were formed in 2012, starting with 2 members for each health post and there is one health post per zone. ZISSP provided motivation for meetings. Each member serves for 1-3 years. There were NHCs before, but they were not active.

ZISSP and SMAGs are working with them and also work with each other. Together they have seen a lot of improvements.

There have been increases in the numbers of deliveries at the clinic once they changed the place of delivery to the other building. SMAGs had kept encouraging clinic deliveries but the women were refusing to come. The SMAG and NHC also constructed a kitchen to provide food and worked with the village headmen. The group also brought the police, a CBO, an Ag group and provided education about gender-based violence, delivering in HF, increasing male involvement in activities. The NHC/SNAG/Headmen have increased male involvement, men should support women and respect them. Increased male involvement means men see woman as a co-worker and they should support each other.

"A lot of women were dying and untrained (didn't know). Now men are working closer with their wives for FP and health services. They are coming earlier for ANCE and men take children to under 5 clinics. We have learned about premature births and newborn care. We learned that we need to prepare ourselves as men and put some money aside to be ready for deliveries. We encourage men to go to SMAG meetings and we pass on the info to others."

One man said that his cousin never agreed to help his wife. Now cousin puts the baby on the back to come to the clinic.

"One woman used to have a lot of stillbirths. SMAG helped her and she was able to deliver successfully."

"One day a woman had a problem and no one was there to help her. A SMAG woman called Serenje and they sent someone to help her for a safe delivery."

"There used to be a lot of hemorrhage. Since ZISSP has trained us here, this has come to an end."

"For FP SMAGs and CBDs were trained in May 2012 in Mkushi. They came back with condoms and pills." "More children are being spaced."

The HCAC received training in Action Plans in 2012. AISSP came to monitor them. This year we are doing the (Action) Plan because we are receiving monitoring. Now we can identify our lapses.

The HCAC includes members who are also CHWs, SMAGs, BCC members, and CBDs.

ZISSP has provided training in Safe Motherhood, FP, BF, NB care, BF, IYCF, taking children for care, using LLINs (mother and children only). There is no spraying in this community. "Sometimes (they) come and ask for an incentive. "We have only heard about spraying but

never had it. We heard about it in other places in Serenje. The last time we got LLIN were in 2006 and 2008. Very few people have nets."

We meet with the health center staff quarterly. We are able to come because we have bicycles. (Some members had rented bicycles to attend today's meeting.). We keep records. The HCAC minutes are kept at the HF, but are written by the secretary of the HCAC.

Re: motivation to be volunteers. "We joined to help the community (pop. 9,800). We will continue because we have seen the bright future."

Serenje Pastors' Fellowship
ZISSP Community Grantee
Serenje District, Central Province
May 10, 2013
Interviewers: Paul Chishimba and Jean Capps

Respondents: Pastor Kevin Mtonga, Project Manager. SPF Chairperson
Pastor John Kaseka, Secretary and Project Financial Manager

Organization was formed 8 years ago and they are a registered FBO with the Office of Civil Society. They started as a spiritual group but became a group of 25 pastors in the district to be part of the fight against HIV/AIDS. Even the churches have this problem. His ministry is the Evangelical Fellowship of Zambia. They receive other funding from Tearfund that gave them money to give 500 families seeds and ground nuts and develop seed banks. They also got money to provide help to HIV+ children and orphans. They also support 3,000 students with uniforms and school funds. They also support animal husbandry programs and education activities.

They now have 42 pastors representing all sections of Serenje as volunteers. They are using ZISSP grant funding to promote nutrition for PLHIV and promote PMTCT in villages. Through ZISSP program they promote HF delivery and go to the hospital as early as possible. They are also forming support groups for HIV+ people and promote the need to seek help with the HW to get ARVs. Drugs are always free.

They also formed a drama groups through ZISSP. There are 4 groups. The main one in Serenje boma has 8 men and 2 women, the second one in Masate is 5 men and 10 women, the third one in Kaseba has 5 men and 17 women and the one in Muchinka is just starting.

For the drama groups they are training 29 HIV volunteer advisors, 20 traditional leaders and 25 pastors and 25 PLHIV/AIDS in 5 communities then they will expand to 6, then 25 more communities for 31 total communities. They are training agents of change, emphasizing the positive. The district CCO is on their committee and they are part of the Serenje district BCC group. They are using the MOH BCC strategy document.

They signed their contract on 20 August 2012 but didn't receive funds until the "launch" in November 2012. The funds are supposed to come monthly, but don't arrive on that schedule.
They started with a meeting in Serenje where 16 groups applied. Three groups were short listed and their organization was assessed in a field visit from ZISSP (about 2 hours). They

would like to apply for additional funding to expand to additional communities, if it is possible. They are not sure if their project ends in August or November. It is a one year program.

KII District Medical Officer
DMO Mkushi District Central Province
May 11, 2013
Interviewers: Paul Chishimba and Jean Capps

She has been a DMO for 18 years. She has attended ZMLA and served as a mentor. She still needs to complete the last session on mentoring. She is also a QI national trainer. They have already applied QI principles and skills from ZMLA at the DHO (taught by ZISSP) to get a new mortuary. Some facilities have applied it to their TB program and saw their TB cure rate rise from 50% to 70%.

In EMONC they used to have 10-13 deaths and now after training they have had only one maternal death. Neonatal care is supported by GSK (money only) and ZISSP helped and now they have added 2 or three trainers. They also trained planners.

They have been conducting mentorship. In Serenje, Kapiri and Mkushi they have functional QI committees. They also looked at technical support together at their last district integrated meetings. They have problems in "the valley" in Mkushi where communities and facilities are extremely hard to reach. They now review action plans and data. This is very helpful because it helps to identify weaknesses and technical support needs. They used this for annual plans based on budget figures in the "yellow book."

ZHWRS
She is in her position with ZHWRS funding but "there is no money for ZHWRS" when she calls. She gets no accounting to continue payments. There are problems with money going to the districts for ZHWRS. It is very efficient "when it works." They will buy a vehicle or a house.

Challenges
Neonates at hospitals. Still have very high numbers of fresh still births but they don't know why. (This is usually an indication of problems during delivery.) FANC is not working well, neither is PMTCT. "We need some root cause analysis to find out why but it is the data that is saying things not going well. We want to do something about these problems.

Mkushi District Medical Office
Acting Planner for Planning and Budgeting
May 12, 2013
Interviewers: Paul Chishimba and Jean Capps

He started his training with a diploma in dental therapy and received a degree in Development Studies with additional training in planning, budgets, economics and development.

He is scheduled to be in the second cohort ZMLA training.

This district budget is supposed to be 720 million kwacha per quarter, but they are getting 360 million and it arrives 2 months late. When this happens they decrease outreach and supervision activities. All HF are supposed to do 90% of scheduled outreaches but only 2 HF (out of 25) met that standard in Jan – June 2012. From July – December 2012 only 2 met that standard. This year the budget is worse than last year. Last year they got 650/quarter. It was late, but they got it.

They have Coartem and RDT stockouts due to reduced funds. They are formulating a revised plan based on reduced funding. "They are only getting 45% of the drugs and supplies they are supposed to receive." ZISSP has not assisted with the revising the action plans based on reduced funding, and they have not done a revised plan as of the second quarter of 2013. They have received training form the ZISSP MS based at the PMO. He has complained about the reduced budget to the MS. They get a "grant" and "funds from GSK". Shortfalls require them to use the grant to buy pharmaceuticals.

He feels "ZISSP needs to share their schedule. As we plan and implement at the district level. There is very little relationship between the PMO and us. . . I would be comfortable if we got serious with the plan we put up and stuck to it."

"In the past revision in work plans were non-standard. He thinks the new form the DMO approves for the action plan will help. This is sent from the DMO to the PMO.

There have already been 4 maternal deaths. They did maternal death audits in the first quarter of 2013.

Mkushi District Medical Office
Ivo Jaliso, Public Health Officer
May 13, 2013

He is an Environmental health Officer and also serves as the malaria focal person for the DMO.
He also served as acting district planner from 2011-2012 and received training from ZISSP. He was involved in the Action Plan launch.

He is involved in malaria prevention. For IRS he was involved form 2010-2012. Out of 9,250 households targeted, they reached 6,543 (71%). Some houses are thatch and are not suitable for IRS. 29,936 households got LLIN in a mass distribution in 2011. About 95% of households received nets through the medical stores. Currently nets are only for MNCH. We convinced the government we had high incidence of malaria. In 2011 it was 310/1000 and 2012 it was 290/1000. There was a bit of a drop, but we don't involve stakeholders or the Council. There really isn't a drop in incidence of malaria. Problems with IRS include not enough insecticides and refusals. Last year insecticide arrived after the rain had already started.

They have health worker shortages. They have 29 CHWs but 4/25 facilities have no qualified staff. ZISSP did a malaria case management training that included NMCC. This included the Pharmacist, Clinical Officer, Lab tech, Nursing Officer. Positivity for malaria remains very high in Mkushi; 80% of slides were positive for malaria. We did BCC through the radio. SMAGS, MCH personnel. We discuss at our meetings and there is a group, MATF Malaria

Focal Team but it isn't funded so we don't meet. There are members from the Council, the old HCP, Police, Prison and DHTIF. There are also malaria agents but they are also not very active. They would need a lot of "motivation" to become active.

His other duties include infrastructure assessments, water, household training on diarrhea prevention, pumps for wells.

Twatasha Health Post
Mkushi District
May 14

Met briefly with Twatasha NHC.

They have been working on building a separate building for deliveries because the HP has only a small room and doesn't provide privacy. "This is disrespectful for the woman." "There were no suitable beds." "We have built the walls with our own resources and got the door and window frames donated. But we need assistance to put on a roof and finish the building." They were not aware of how to apply to the constituency funds and link with the MCDMCH office in the District. The MCDMCH representative on the team continued with the meeting and provided them with information on how to find the MCDMCH office to seek CD funds to support their work.

ZISSP supported them to develop the Twatasha Drama Group consisting of 4 men and 2 women. They were active in the measles campaign and providing diarrhea, malaria, FP messages. They are supposed to go out into their catchment area 3 times a month but they have no support to do that now. They were trained by Ms. Mtonga (the ZISSP CHC).

The rest of the interview was finished by the MCDMCH representative on the team.

Community Health Assistants
Key Informant Interview
Twatasha Health Post, Mkushi District
Central Province, May 14, 2014

Met two CHAs, one woman and one man.

They were selected by their communities because they wanted to serve their communities. They have been on site since September 2012. They were trained from May 2011 to July 2012. Prior to that one was a malaria agent for 6 years and the other (the woman) had been on the NHC for 1 year.

Their duties include Health education and curative services for the whole population. Their training included child health, maternal health, disease and family planning. They also do environmental health. Both of them had just returned from Ndola where they got additional training in delivery. They did not get any practice. They observed two deliveries and said they would need more practical experience before they could do a delivery. They worked on models.

They have goals to visit around 10 houses per day. There are 582 households in their catchment area. They also spend 2 hours in the morning at the health post and spend afternoons in the community.

Neither of them have received any supervision of their community work. The Enrolled Nurse at the HP is not their supervisor but she does supervise them when they are at the HP. The male CHA sought out his supervisor at the health center (20 km) away and found out he had no transport to supervise him and considered himself to be the "wrong" person to have been trained as a supervisor.

They have received no "kits" or drugs for community curative care. They got only folders but no bags and no supplies. " After working 9 months, they have only been paid for 5 months. They got paid for Feb. and March as a block. They had not received anything since March (this was May.)
KII CHA Supervisor
Health Center In Charge,
Mkushi District, Central Province
May 14, 2013
Interviewers: Jean Capps and Paul Chishimba

He has been a Clinical Officer for 5 ½ years.

CHA training was early last year. Supervisor training was in August and September 2012. The expectation was that CHA's would be supervised monthly. The challenge is the CHAs are not in the catchment area of the health center. The supervisor is supposed to meet them at their place of work, supply them with reporting forms and registers and integrate their data into his reports.

"But there is a nurse at Twatasha HP but they went and got me from the HC to be the supervisor." "The distance is too far—it is over 20 km and there is no motorbike. (The HC has one, but it is broken and hasn't been repaired by the DMO due to shortage of funds.) "The instructions for selecting supervisors from the DHO was wrong. They went to Ndola Training Center for 5 days. It was brought to their attention that 4 supervisors from Mkushi District had no CHAs in their catchment areas. There has also been no follow up after the training. He is not sure who the district CHA coordinator is. The District Clinical Care Officer should be the district CHA coordinator. In other districts it was that way, but our Clinical Care Officer was at the QI training and couldn't come so they sent Mr. Jaliso (the EHT PHO).

He has "turned over the supervision" role to the Enrolled Nurse at Twatasha. "We were wrongly trained."
Kapiri Moshi District Health Officer
KII Clinical Care Officer
May 15, 2013
Interviewers: Jean Capps and Paul Chishimba

He has been a clinical officer since 1986. He worked in a RHC in Kapiri and was trained in IMCI by HSSP. He was also trained as an IMCI trainer by CARE. But has never trained anyone.

ZMLA- We learned a lot such as how to hold meetings, delegate responsibilities, write and agenda and keep to it and use meeting time efficiently. It has helped him to avoid doing everything himself, set priorities in planning for impact and how to use information for planning.

Clinical Mentorship – He was trained in 2011. They go to the health centers and look at case histories, observe IMCI performance. The team is multidisciplinary. We divide ourselves into teams of 3 people each. ZISSP helps with allowance and fuel for support. Sometimes they pay for meals and lodging if they have to travel far.

Sustainability – We will continue mentorship but not at the same level due to lack of resources. MCH, Sr. EHO, nutritionist, Medical Licensate, TB focal person and HCT coordinators participate. There are also lay counselors trained by ZPCT2. Some lay counselors that were trained by MSF were continued to be paid by government after they left. He hopes government will continue with the others.

QI/QA: He missed the training due to a performance assessment. He is a QI committee member but co-ordinator hasn't been trained. QI is to "make sure things are done properly and clients are satisfied." He doesn't know when ZISSP will train. Even though he wasn't in the training, the manual is very good. Those who were trained were from the district hospital and Makonje RHC, only 3 HF. "We hope we get to form 3 more QI committees. We will continue supporting them after ZISSP is over."

Overall ZISSP has been good. He likes the mentorship. "We are seeing improvements. This is our baby and not just academic. In some centers, when we go for PA, we have received some complements—before, only complaints."

He would like to get "hands on" experience as an IMCI trainer. He was trained as a trainer but never did it.

KII Principal Nursing Officer (PNO)
Kapiri Moshi District, Central Province
May 15, 2013
Interviewer: Jean Capps

MCH is under PNO supervision. She sees that nursing care is according to standards of care. She appraises performance and makes recommendations for training and promotion. She advocates for equipment, materials and lobbies for instruments.

The LTFP trainees got a pack. She budgeted for LTFP and got donated autoclaves from a donor. IUDs and equipment are actually there as a result of her efforts. They were trained in Kabwe. There are RHCs remaining. There is no outreach for LTFP. The distances are long and there are only a few places. They have no supply problems (unlike other districts). Demand is high.

She was also selected by management as a trainer, supervisor and mentor for CIMCI. They had two other partners that helped with IMCI training: CARE and ADRA, there hasn't been any supported by ZISSP in their district.

ZMLA – Very good training and she liked it. It helped give them skills in planning, budgeting, managing human resources and orienting new employees. This will really help with orienting and (hopefully) retaining new nurses. Included information on showing new nurses what is expected, their job description, professional regulatory framework, etc. This includes the role for the RN and the community.

Mentorship – both PNO and Nutritionist were trained in 2010 and 2011 respectively. We do this based on what is found in performance assessments. She gave an example of PMTCT. "This needs hands-on mentorship. We work side by side sometimes for 2 days to do mentorship. That never used to happen. We split up to not overwhelm them like we did in TSS visits. We make a follow up plan. We need to continue our grants because they are not consistent with our Action Plan. We budget a certain amount but adjust our activities. "Trainings are the first to be dropped when resources are limited. Hospital inpatient care gets first priority."

In 2012 stockouts were not a problem. Now they have shortages of amoxicillin and they have no coartem; they are using quinine. They also have problems with other drugs.

QI team was just formed in March. It includes community members, NGOs and district medical officer. They are trying to orient NGOs to their roles. Facilities have had a QI committee since November 2012.

Management trainings: "You are just appointed (to your job) without any orientation. They (ZMLA) helped us in how we ran the office. It includes content on using info (quantitative data), e.g. how many malaria cases by gender, as you plan.

ANNEX XV: KEY PERSONNEL BIOGRAPHICAL INFORMATION

Key Personnel Biographical Information

Jean Capps, Evaluation Team Leader. Ms. Capps is a global health and development expert with over 20 years of experience in all aspects of public health including HIV/AIDS, child health, malaria, tuberculosis and reproductive health. She has extensive experience in assessing global development projects as well as leading, managing, planning, monitoring and advising on global health around the world. Ms. Capps has worked for numerous international donors - USAID, Concern Worldwide, World Relief, UNHCR – in many African countries including Zambia, Zimbabwe, Ethiopia, Ghana, Rwanda, Uganda, Nigeria, Malawi and Somalia.

Ms. Capps has significant experience leading and/or participating in evaluations of public health programs similar to ZISSP. In Zambia, she led the final evaluation of the USAID–funded Child Survival Project. In Zimbabwe, she led a team that conducted the evaluation of CIDA/Food Security project, which analyzed the impact of the project on women's agro-processing groups and child nutrition. In Ethiopia and Tanzania, she led the final impact evaluation of the USAID-Child Survival Project, which included an analysis of project activities on women and the poor. In Sierra Leone, she was Team Leader for the evaluation of the USAID/Child Survival Project for which she assessed interventions including HIV/AIDS, malaria, immunizations, nutrition and maternal/newborn care. In Malawi, as a community mobilization specialist, she assessed project effectiveness in preventing HIV/AIDS transmission by targeting vulnerable groups of different genders and ages. In Angola, as HIV/AIDS, Malaria and TB Specialist, she assessed technical assistance provided, conducted risk assessment, and recommended corrective actions to USAID. In Pakistan, Ms. Capps led a participatory evaluation and gender analysis for the USAID-funded Family Planning and Reproductive Health project.

Ms. Capps has extensive public health experience. As a Child Health and Nutrition Specialist, she worked in the USAID/Guatemala Portfolio Gap Analysis, where she designed a new analytical plan to measure program results in maternal and newborn health and nutrition. For Concern Worldwide, Ms. Capps drafted a field manual on social and behavior change communication in health, HIV/AIDS, water and sanitation, gender-based violence, nutrition, and livelihoods for program managers. As a Program Analyst for the Office of Food for Peace at USAID, Ms. Capps backstopped Title II development programs to support food security, agriculture, education, and water/sanitation. As a Technical Advisor to USAID, she provided technical advice and backstopping for PVO child survival, maternal and newborn care, reproductive health, and nutrition programs in Latin America, Africa and Asia. Furthermore, Ms. Capps has extensive clinical nursing experience, and has worked as a Refugee Public Health Nurse and Health Center Manager in a refugee camp in Somalia. She has also been a Community Health Advisor for the UNHCR.

Ms. Capps has a Master's in Public Health from Johns Hopkins University and a Bachelor in Nursing from Georgetown University. Ms. Capps speaks English, French and Spanish.

Deborah McSmith, Program Evaluation Specialist. Ms. McSmith is a global health professional with over 20 years of experience in HIV/AIDS, maternal newborn and child health, and integration of health services. She has worked on designing, implementing and evaluating health programs in many African countries including Zimbabwe, Namibia, South Africa, Tanzania, Sudan, Mozambique, etc. Ms. McSmith is experienced in conducting needs

and feasibility assessments and evaluations for projects sponsored by a number of international donors, including USAID, UNFPA, CARE and others.

Ms. McSmith has extensive experience evaluating health programs throughout the world. In Zimbabwe she was Team Leader for a USAID final performance evaluation of an OVC project. She assessed whether the project developed innovative, sustainable and effective models of service delivery and the extent to which processes were institutionalized within government structures. For the UNFPA, as part of a dual evaluation of UNFPA's support to Maternal Health, she conducted country case studies in Ghana, Ethiopia, and Sudan. In South Africa, she conducted the final evaluation of a USAID-funded HIV/AIDS capacity building project, where she met with leaders in four provinces to review national support strategies and capacity building methodologies for local partners, and recommended strategies for improvement. For USAID/Malawi, she conducted a mid-term evaluation on a pediatric and HIV services project, where she assessed district partnerships and capacity building as well as PMTCT and pediatric HIV services, including nutrition, malaria prevention, etc.

Ms. McSmith is skilled in the design, implementation and management of health programs, in particular in areas of maternal and child health, HIV/AIDS, and institutional capacity building. In Cambodia, she was Team Leader for the Strengthening Capacity for Improved Community Health project, which focused on HIV/AIDS, reproductive health and family planning, as well as maternal and child health and nutrition. In Sudan, she worked to design and conduct surveys to inform integrated programming for Sexual and Reproductive Health, Gender Based Violence and Youth Civil Participation for 2013-2016 country program. In Ethiopia, she provided technical support to USAID Mission there for the development of a PEPFAR PMTCT Accelerated Plan, Country Operational Plan, and other work plans. In Zimbabwe, she supported USAID Mission to develop program design for PMTCT program. She was interim technical and operations manager for the Southern Africa Human Capacity Development Coalition, where she focused on capacity building for human resources for health. She also served as the HIV/AIDS Regional Advisor for CARE in Asia and provided technical support to the country office in Asia for HIV/AIDS related programs and projects.

Ms. McSmith has a Masters of Public Health from UC Berkeley and a BA from Amherst.

Beatrice Chikotola, Local Expert. Ms. Chikotola is a Zambian health specialist with over 20 years of experience in health related programs sponsored by a number of donors such as USAID, UNPF, CARE International, etc. She has significant expertise in the areas of HIV/AIDS and reproductive health and has worked on evaluations, needs assessments, and data collection and analysis. She has served in various capacities with the MOH and has worked on mainstreaming HIV/AIDS and reproductive health activities with other health services, including livelihood, nutrition, economic empowerment and gender.

Ms. Chikotola has ample experience designing, implementing and evaluating HIV/AIDS programs throughout Zambia as well as other African countries including Angola, Mozambique, Malawi, South Africa, Uganda, Zambia, and Zimbabwe. From 2005-2009, she served as an HIV/AIDS Program Advisor on the first Zambia HIV/AIDS Prevention, Care and Treatment Partnership with USAID. In this capacity she provided technical, programmatic and financial oversight and served as liaison between USAID and GRZ. As a Regional HIV/AIDS Workplace Program Implementation Manager in Southern Africa, she established best practices model for implementing HIV/AIDS treatment services. In Uganda, she consulted with various NGO and faith-based organizations on HIV/AIDS programs and

was the lead writer for the HIV/AIDS Training for Church Leaders. For Oxfam, Ms. Chikotola evaluated which Oxfam office locations in Zambia had inadequate medical infrastructure in order to provide recommendations for improving access to HIV/AIDS services.

Ms. Chikotola has experience in conducting evaluations of health projects. For Care International, she worked on participatory appraisals, baseline surveys, health facility needs assessments and development of monitoring and evaluation tools. For MOH, she participated in the evaluation of the ART Strategy. For Oxfam, she was Principal Investigator for the HIV/AIDS Workplace Programme Situation Analysis. For United Nations Population Fund in Zambia, she was Team Leader of the Reproductive Health Rapid Appraisal. And for UNFPA, she was Principal Investigator of Health Facilities Reproductive Health Needs Assessment.

Ms. Chikotola has an MPH and a BS in Nursing from the University of Zambia.

Kumbutso Dzekedzeke, Local Expert. Dr. Dzekedzeke is a Zambian expert with over 15 years of experience in the area of public health. With significant expertise in statistics and health economics, he has developed data collection methodology and conducted statistical analysis of HIV/AIDS, malaria, PMTCT, reproductive health, and other projects throughout Zambia. Dr. Dzekedzeke has worked on health resources and management information systems. He has worked regularly with the Zambian Ministry of Health and numerous international donors such as USAID, UN, WHO, and others.

Dr. Dzekedzeke has extensive experience conducting analysis of data and designing mini-surveys, household surveys and questionnaires. As a Data Analysis Consultant for the World Bank, he worked on the validation and quality assurance of all the data collected and generated frequency tables for 10 surveys. For the Futures Institute, he worked to develop tools to collect, compile, and analyze data to estimate costs of PMTCT and paediatric antiretroviral interventions (ART). For the Population Council of New York, he served as a Sample Implementation and Research Data Collection, and was part of team that assessed the interventions program funded by the UK government to improve the livelihood and survival of young women in rural areas of Zambia. He also developed schemes for a series of household surveys and recruited participants for long-term HIV prevention microbicides simulated trials. From 2009-2010, he used survey data, available records and the health management information system to build a RAPID model for a family planning program in Zambia. He trained staff from the National AIDS Council, MOH and Department of Census and Statistics in the use of a UNAIDS epidemiological model for estimating and projecting cases of HIV and AIDS using data from surveys, censuses and the health management information system.

Dr. Dzekedzeke has significant experience evaluating and assessing health projects. For the UN he evaluated and identified issues for future programming for the GRZ and United Nations Population Fund country program for the health sector. For the US National Institute of Health he was one of the lead investigators in an assessment to learn about improving the provision of sexual and reproductive health services, including HIV and pregnancy related care. For WHO he assessed the progress in scaling up PMTCT in ten districts in Zambia. For GRZ he assessed and proposed measures to improve the efficiency of the HIV prevention response in the country. He also conducted a strategic assessment of

unsafe abortions in Zambia and produced epidemiological estimates and projections of the HIV/AIDS epidemic in the country.

Dr. Dzekedzeke has a PhD, an MA in population studies and a BA in demography and economics. He speaks English, Chewa and Bemba and is a proficient user of SPSS and STATA statistical software.

Paul Chishimba, Local Expert. Mr. Chishimba is a Zambian specialist with 20 years of experience working on projects that cover a range of public health issues including HIV/AIDS, malaria, and maternal and child health. He has extensive experience in conducting evaluations of health projects and designing and implementing monitoring and evaluation tools and reporting systems. He has worked with a number of international donors including USAID, World Bank, the Bill and Melinda Gates Foundation, EU, European Development Fund, UNICEF and WHO.

Mr. Chishimba has considerable experience conducting evaluations and studies, designing and redesigning reporting systems, and developing indicator sets for health programs in Zambia. As Research Project Manager for the World Bank in Zambia, he is currently implementing a study in 7 provinces that is investigating the GRZ's efficiency in delivering HIV services. As a Consultant for the EU, he conducted the evaluation of the Zambia Health Management Information System, the primary objective of which is improving the efficiency and effectiveness of health care delivery in Zambia by strengthening the country's health management information system (HMIS) in order to enable stakeholders to make better informed decisions. For the EU, the Ministry of Finance and MOH, he developed an indicator set for monitoring the performance of hospitals in Zambia. As a Demographer/Statistician for WHO/UNFPA, he revised and simplified the information system for maternal and child health in collaboration with the MOH and the Directorate of Monitoring and Evaluation at the Central Board of Health. For MOH, NMCC, and the National AIDS Council he reviewed their capacities to conduct and manage health programs that covered HIV/AIDS, malaria, and reproductive health services.

Mr. Chishimba has two Post Graduate Diplomas in Public Health from the University of the Western Cape and a BA in Demography from the University of Zambia. He is proficient in using data capturing and analysis software including SPSS and STATA.

ANNEX XVI: DISCLOSURE OF CONFLICT OF INTEREST

ANNEX VI: DISCLOSURE OF ANY CONFLICTS OF INTEREST

[The Evaluation Policy requires that evaluation reports include a signed statement by each evaluation team member regarding any conflicts of interest. A suggested format is provided below.]

Name	Jean Capps
Title	Consultant
Organization	Mendez England
Evaluation Position?	☒ Team Leader ☐ Team member
Evaluation Award Number *(contract or other instrument)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Zambia Integrated System Strengthening Program (ZISSP)
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	Jean Marie Capps
Date	10 June 2021

ANNEX VI: DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	Deborah McSmith
Title	Consultant
Organization	ME&A
Evaluation Position?	Team Leader Team member XX
Evaluation Award Number *(contract or other instrument)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	OVC Final Evaluation, Zimbabwe 2012 UGM Final Evaluation, South Africa 2012 BASICS II Mid Term Evaluation, Malawi, 2010 High Risk Corridor Initiative Project Final Evaluation, , Ethiopia, 2008
I have real or potential conflicts of interest to disclose.	Yes No XX
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to: 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the*	

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June 11 2013 Deborah McSmith

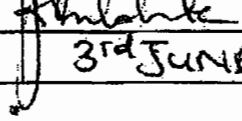
Name	Deborah McSmith
Title	Consultant
Organization	ME&A

ANNEX VI: DISCLOSURE OF ANY CONFLICTS OF INTEREST

[The Evaluation Policy requires that evaluation reports include a signed statement by each evaluation team member regarding any conflicts of interest. A suggested format is provided below.]

Name	KUMBUTSO DZEKEDZEKE
Title	MR
Organization	
Evaluation Position?	☐ Team Leader ☒ Team member
Evaluation Award Number *(contract or other instrument)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	3rd JUNE 2013

ANNEX VI: DISCLOSURE OF ANY CONFLICTS OF INTEREST

[The Evaluation Policy requires that evaluation reports include a signed statement by each evaluation team member regarding any conflicts of interest. A suggested format is provided below.]

Name	BEATRICE CHIKOTOLA
Title	LOCAL CONSULTANT
Organization	
Evaluation Position?	☐ Team Leader ☑ Team member
Evaluation Award Number *(contract or other instrument)*	CONTRACT
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	ZISSP PROJECT
I have real or potential conflicts of interest to disclose.	☐ Yes ☑ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	Bkchikotola
Date	May 03, 2013

ANNEX VI: DISCLOSURE OF ANY CONFLICTS OF INTEREST

[The Evaluation Policy requires that evaluation reports include a signed statement by each evaluation team member regarding any conflicts of interest. A suggested format is provided below.]

Name	PAUL CHISHIMBA
Title	LOCAL CONSULTANT (ZISSP MTE)
Organization	MEA
Evaluation Position?	☐ Team Leader ☑ Team member
Evaluation Award Number *(contract or other instrument)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	ZAMBIA INTEGRATED SYSTEM STRENGTHENING PROGRAM
I have real or potential conflicts of interest to disclose.	☐ Yes ☑ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

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Signature	
Date	03/06/2013