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Assessment of the MCSP Technical Assistance Model to Support Zambia's RMNCAHN Continuum of Care Program

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Acronyms

ANC	Antenatal Care
ASRH	Adolescent sexual and reproductive health
CE	Community Engagement
CoC	Continuum of Care
DfiD	Department for International Development
DHIS2	District Health Information Software 2
DHO	District Health Office
DHPT	District Health Promotion Team
DMT	District Mentorship Teams
EmONC	Emergency Obstetric and Newborn Care
G2G	Government-to-Government
GMP	Growth Monitoring and Promotion
GRZ	Government of the Republic of Zambia
HCC	Health Center Committee
HCW	Health care worker
KII	Key Informant Interview
HMIS	Health Management Information Systems
MCSP	Maternal and Child Survival Program
M&E	Monitoring and Evaluation
MER	Monitoring, Evaluation and Research
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
PHO	Provincial Health Office
PMP	Performance Monitoring Plan
SMAG	Safe Motherhood Action Group
SME	Subject matter expert
QI	Quality Improvement
RED	Reaching Every District
RMNCAHN	Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition
SBH	Systems for Better Health
SIDA	Swedish International Development Cooperation Agency
SM360	Safe Motherhood 360+
SQA	Service Quality Assessment
TA	Technical Assistance
ToC	Theory of Change
TOT	Training of trainers
USAID	U.S. Agency for International Development

Executive Summary

To improve reproductive, maternal, newborn, child, adolescent health and nutrition (RMNCAHN) outcomes, the government of Zambia (GRZ) developed a national health strategic plan 2017-2021, which includes the reproductive, maternal, newborn, child and adolescent health, and nutrition (RMNCAHN) Continuum of Care (CoC) program. The RMNCAHN CoC program aims to improve RMNCAHN through increasing availability and readiness of quality health and nutrition services, increasing demand and uptake of physically, culturally, and financially accessible services, and strengthening health systems at national and sub-national levels. The CoC program is led by the Ministry of Health and supported by different partners, including the US Agency for International Development (USAID) and Swedish International Development Cooperation Agency (SIDA) through a Government to Government (G2G) grant.

The USAID Maternal and Child Survival Program (MCSP) in Zambia provided technical assistance (TA) to the MOH to implement the G2G funded RMNCAHN CoC program from 2017-2018. MCSP works in each of the 42 districts in Muchinga, Southern, Eastern and Luapula Provinces, providing demand-driven TA to the Zambia MOH at the national, provincial, district, and facility levels. MCSP does not support direct service delivery at the facility level; the program supports the MOH to plan and implement high impact RMNCAHN interventions directly funded by the G2G granting mechanism and the GRZ. MCSPs support focused on district capacity strengthening to conduct evidence based planning, multidisciplinary RMNCAHN mentorship, facility service quality assessments, facilitate clinical trainings, utilization of scorecards and HMIS tools for program decision making and hands-on facility level clinical mentorship where feasible.

In 2018, MCSP conducted a two-phased assessment to document lessons learned from implementing this unique TA model within the RMNCAHN program context. This information will be useful for scale up of this model to other settings. Specifically, the assessment sought to understand the acceptability of TA without direct funding for service delivery; the ability of MCSP to influence technical direction of activities implemented with G2G funds; the extent to which project objectives were achieved; and the factors that affected the results. Two phases of data collection captured two time points of stakeholders' perspectives on MCSP TA. The first phase provided feedback that was used to strengthen MCSP implementation and the second phase was conducted as the project was closing out to inform recommendations for future programming. Data were collected using qualitative and quantitative methods. MCSP conducted key informant interviews to obtain feedback from stakeholders on the levels of acceptance and results of the TA model, lessons and best practices from the MCSP TA, and recommendations for future programming. MCSP also conducted analyses of routine data from the DHIS2 and the project database to determine the extent to which project intermediate results (IR) were achieved. Phase I data were collected in July 2018 and Phase II data in December 2018. Phase II data was also used to highlight any changes in stakeholder perspectives across the study objectives over time.

The specific objectives of the assessment were to:

- Assess the acceptability of technical assistance among MOH staff at national, provincial, district and facility levels;
- Determine the level of influence on district and facility level activities;
- Determine the extent to which project intermediate results are achieved; and
- Understand the major factors influencing the achievement or non-achievement of these results.

Results

To analyze the acceptability of the TA model among MOH staff at national, provincial, district and facility levels, key informants were asked about their awareness of MCSP's objectives and activities, and the degree to which they interacted with project activities and personnel. In both phases, the assessment found that most informants were aware of MCSP, understood the project objectives and described favorable interactions between themselves or their subordinates and MCSP. However, during the first year of the program, most provinces/stakeholders did not quite understand the purpose of the proposed technical assistance model. This became clearer though in the second year of the program, when TA visits increased, the CoC team began providing TA as a team, and after joint presentations were made during key stakeholder meetings. In addition, faster disbursement and smoother flow of funds for implementation of activities following the operationalization of Navision, contributed to an increased understanding of the purpose of MCSP's TA. The assessment also found that national level informants reported fewer interactions with MCSP, which was cited as a weakness. There were also concerns about MCSP not directly funding activities, with informants indicating that there were funding gaps MCSP could support. Informants continued to request for this support despite clarification on the CoC program structure and G2G grants, with more stakeholders citing this challenge in Phase II than in Phase I.

The level of influence on district and facility level activities relied heavily on MCSP's ability to engage districts during the CoC planning process to ensure that high impact interventions (HIIs) were included in the CoC plans and budgets, as these were the interventions for which TA would be provided. In situations where CoC funds were not available or adequate for the interventions recommended by MCSP, providing TA would be challenging. In both phases, key informants from most districts indicated that MCSP provided TA in identifying and prioritizing HIIs for inclusion in the districts plans. Informants from the four Provinces reported receiving TA from MCSP that included capacity building in Service Quality Assessments (SQA) and mentorship. Facility level informants described TA as focused on hands-on clinical capacity building such as mentoring in labor management, use of partograph, resuscitation and birth asphyxia management, PPH management, infection prevention, newborn care, cold chain management and utilizing facility dashboards to improve services as was expected. Interviews stated that these initiatives strengthened systems by deploying and optimizing existing tools. Two TA strategies featured more prominently in Phase II results than in Phase I and were mentioned by the most MOH informants: the use of scorecards for decision-making and increased health facility level supportive visits by teams of MCSP staff and MOH mentors.

To address skills gaps among facility level providers, MCSP supported the MOH to establish and strengthen mentorship teams at the district level. Key district personnel in all 42 districts were oriented and trained, and 21 districts now have functional mentorship teams that cover all RMNCAHN thematic areas. Strengthening community engagement, another IR, also gained traction during the technical assistance period with the formal identification and designation of District Health Promotions Team (DHPT) representatives including private sector and civil society organization (CSO) partners in 24 District Health Offices (DHOs). Two hundred and sixty nine (269) of 294 district personnel along with 564 of 1009 targeted facility personnel were mentored on community engagement approaches. A majority of MOH informants at all levels reported awareness of MCSP's support for both RMNCAHN services mentorship and community engagement systems strengthening.

Quantitative findings showed substantial improvement in the uptake and utilization of RMNCAHN services in the four MCSP-supported provinces, as evidenced by increased performance of some key service delivery indicators in 2018 compared to 2017. Results showed an increase in:

- Women attending their first antenatal care (ANC) visit before 14 weeks from 15% in 2017 to 26% in 2018;
- Women receiving at least four ANC visits from 34% in 2017 to 46% in 2018;

- Institutional deliveries from 64% in 2017 to 68% in 2018;
- Postnatal care visits within six days from 50% in 2017 to 64% in 2018.
- The proportion of newborns dying from birth asphyxia reduced from 14% in 2017 to 2% in 2018 across the supported provinces.
- The percent of fully immunized children from 79.5% in 2017 to 87% in 2018 in Muchinga province

There were however declines in a few PMP indicators, with the still birth rate increasing from 1.5% in 2017 to 1.7% in 2018, early initiation of breastfeeding declining from 88% to 69%, and children underweight increasing from 0.8 to 0.9%.

Recommendations from the interviews included the need to:

- Provide clarity about the TA partners' roles, manage expectations that the TA does not come with financial resources to support implementation of activities, and emphasize the intricate linkage between CoC resources and MCSP's TA;
- Ensure active involvement and participation of national level MOH leadership through consistent interaction in TWGs and routine progress updates, as these stakeholders are ultimately accountable for systems strengthening efforts.

MCSP identified several promising TA practices from the interviews that contributed to the effectiveness of this TA model:

- Participation in annual PHO and DHO planning processes with emphasis on the use of performance data (from DHIS2 and other sources) to inform annual plans;
- Engagement of districts to review performance using scorecards and assessment results before beginning the annual planning process to design prioritized and responsive district plans;
- Regular engagement and participation in monthly meetings to support DHO teams during review of planned activities and support for follow-up on delayed activities;
- Participation in weekly DHO planning meetings to assist coordinating and scheduling upcoming activities that would benefit from TA;
- Participation in mentorship planning to identify areas of focus and organize the necessary materials and human resources before mentorship;
- Integration of activities with other partners at the provincial level to improve the quality of TA provided to the districts and facilities;
- Co-location of MCSP TA staff within DHO offices to facilitate close coordination and accessibility of TA providers;
- A robust system for operational /logistics support for TA delivery to mentors and from mentors to mentees;
- Dual focus on capacity strengthening for service delivery and demand creation i.e. including mentorship TOT on health promotion.

Introduction

Zambia made significant progress in reducing its maternal mortality ratio (from 729 to an estimated 398 per 100,000 live births) between 2001 and 2014. However, gaps remained in the quality and coverage of essential health services to address maternal, newborn and child morbidity and mortality. For example, only 64% of deliveries are attended by a skilled birth attendant (31% in rural areas)[1]. While there has been a decrease in neonatal mortality since the early 2000s, the rate has stagnated over the last 10 years. Infant mortality decreased from 107/1,000 in 1992 to 45/1,000 in 2014, but did not reach the Millennium Development Goal (MDG) target of 35/1,000 [1]. To further improve reproductive, maternal, newborn, child, adolescent health and nutrition (RMNCAHN) outcomes, the government of Zambia (GRZ) developed a national health strategic plan 2017-2021, which includes the reproductive, maternal, newborn, child and adolescent health, and nutrition (RMNCAHN) Continuum of Care (CoC) program. The RMNCAHN CoC program aims to improve RMNCAHN through increasing availability and readiness of quality health and nutrition services, increasing demand and uptake of physically, culturally, and financially accessible services, and strengthening health systems at national and sub-national levels. The CoC program is led by the Ministry of Health and supported by different partners, including the US Agency for International Development (USAID) and Swedish International Development Cooperation Agency (SIDA) through a Government to Government (G2G) grant.

The G2G RMNCAHN CoC program supports six of Zambia's ten provinces. Although implemented by the MOH, the RMNCAHN CoC Program is funded by Swedish International Development Cooperation Agency (SIDA), United States Agency for International Development (USAID) and the UK Department for International Development (DFID) through the G2G mechanism. USAID disburses its funding through SIDA to Luapula and Muchinga provinces, SIDA funds Eastern and Southern provinces directly and DFID funds Central and Western provinces. In addition, USAID funds technical assistance through MCSP to four out of the six CoC program provinces.

The objectives of the CoC program are to:

- Increase availability and readiness of quality health and nutrition services for mothers, newborns, children and adolescents;
- Increase demand and uptake of physically, culturally, and financially accessible services for mothers, newborns, children and adolescents; and
- Strengthen health systems at national and sub-national levels as necessary.

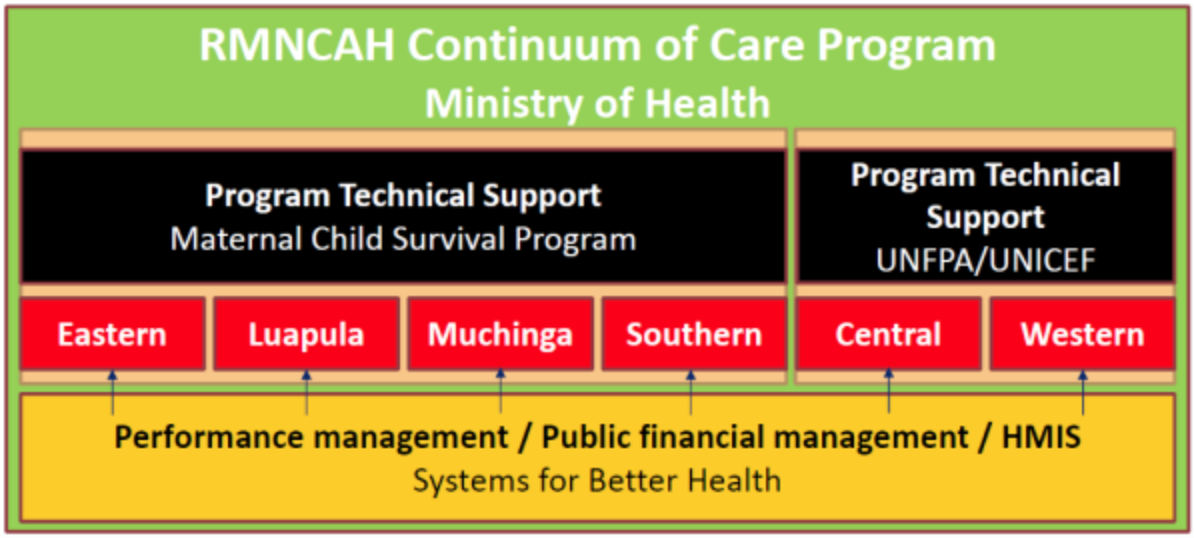
The USAID Maternal and Child Survival Program (MCSP) in Zambia provided technical assistance (TA) to the MOH to implement the G2G funded RMNCAHN CoC program from October 2017-March 2018. MCSP worked in each of the 42 districts in Muchinga, Southern, Eastern and Luapula Provinces, providing demand-driven TA requested by the MOH to counterparts at the national, provincial, district, and facility levels. MCSP did not support direct service delivery at the facility level; the program supported the MOH to plan and implement high impact RMNCAHN interventions directly funded by the G2G granting mechanism and the GRZ. MCSP's support focused on district capacity strengthening to conduct evidence based planning, multidisciplinary RMNCAHN mentorship, facility service quality assessments, facilitate clinical trainings, utilization of scorecards and HMIS tools for program decision making and hands-on facility level clinical mentorship where feasible.

USAID's MCSP and the Systems for Better Health (SBH) project jointly provided TA to the RMNCAHN CoC program and supported development of evidence-based G2G fund plans and mid-term expenditure

[1] *Zambia Demographic and Health Survey* 2013/14

framework (MTEF) plans, and provide technical support for delivery of recommended high impact RMNCAHN interventions based on the plans. SBH provided TA on performance management, public financial management and HMIS strengthening to all six provinces.

Figure 1. G2G RMNCAH CoC Partners



MCSP improved the quality and delivery of high impact RMNCAHN interventions under the following objectives:[2]

1. Provision of demand-driven technical assistance to the district and facilities for sustainable scale-up of RMNCAHN interventions across the national, provincial, districts and facility levels;
2. Developing institutional collaboration aimed at increasing local capacity in RMNCAHN by catalyzing the twinning of a local institution with a regional or global counterpart that will extend beyond the life of MCSP;
3. Developing e-learning training courses for health care workers to improve provider knowledge and for skills acquisition and retention.

Under Objective 1, MCSP focused on strengthening each district's ability to lead the planning and provision of integrated and comprehensive RMNCAHN services at the health facility and community levels. In collaboration with the District Health Office (DHO), the program worked closely with provinces and districts to strengthen the rollout of packages of high impact interventions. The program was not intended to reach all facilities within these districts; however, MCSP did provide some TA directly at the facility level in response to specific demand-driven requests based on availability of funding. TA support to health facilities was typically conducted jointly with district personnel and served as an opportunity to provide hands on practical mentorship to DHO teams.

MCSP TA focused on equipping DHO personnel with the necessary knowledge and skills to build the capacity and provide supportive supervision to health care workers at the facility level, and allow the health care workers to consequently build the capacity and provide supportive supervision to community based volunteers as they engage in activities for demand generation at the community level. To improve the health care workers' competencies, MCSP worked closely with districts to establish functional multidisciplinary

[2] This assessment relates primarily to MCSP's Objective 1.

mentorship teams tasked with conducting regular mentorship and supportive supervision activities using MOH guidelines and tools. MCSP's theory of change is presented in Figure 2.

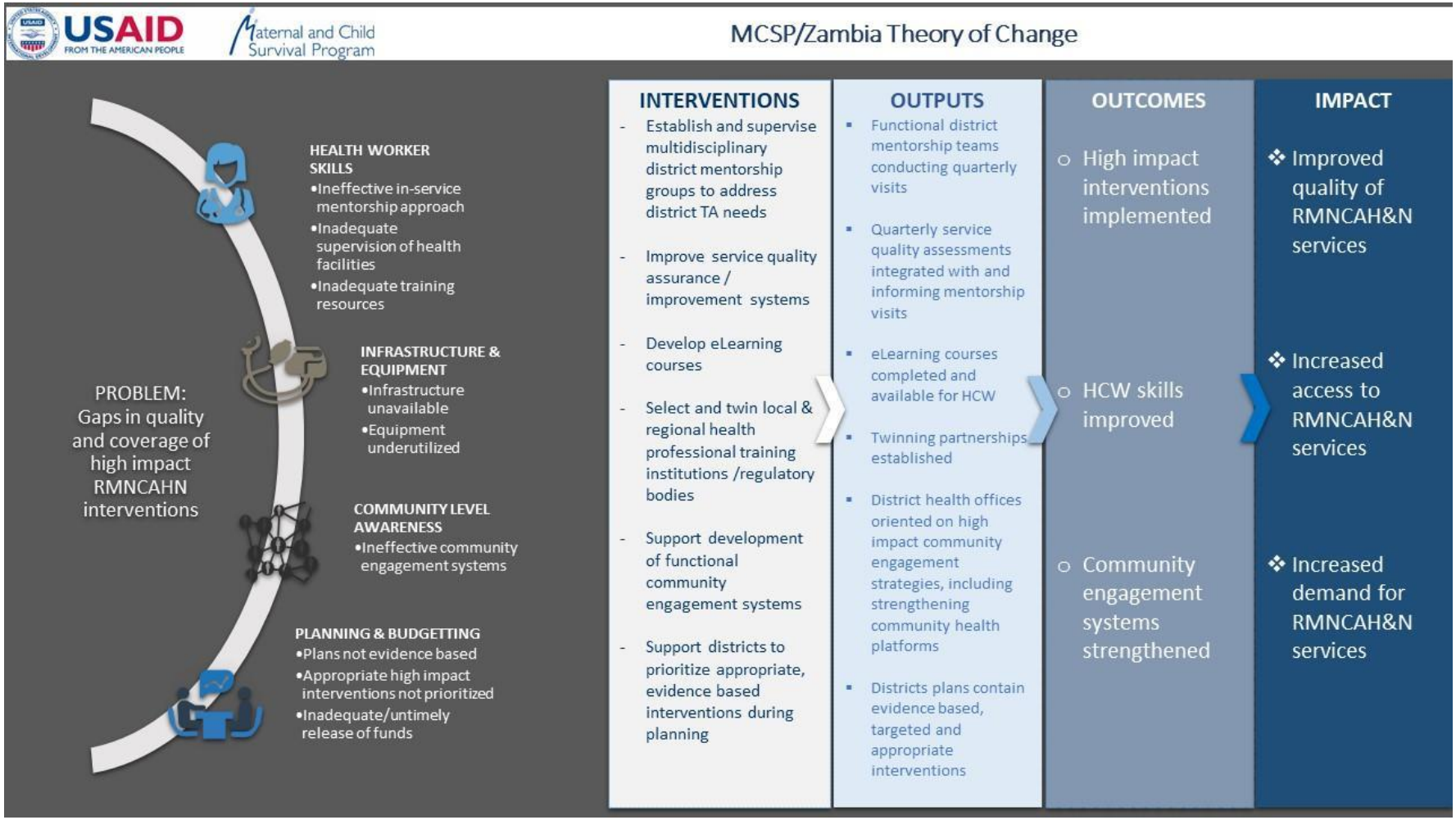
MCSP's model of providing demand-driven TA to a G2G-funded, MOH-led program is relatively new in Zambia. This approach to TA provision, compared to direct service delivery support, has not been implemented or studied before in Zambia. Therefore, MCSP developed an assessment to identify lessons learned and challenges in implementing this unique model of demand-driven TA in support of the MOH-led CoC program. In particular, the assessment examined the degree to which MCSP Zambia was able to influence MOH-led activities in the absence of direct funding; the extent to which the project achieved its objectives; and major factors that affected the achievement of positive or negative results. This report details the assessment and its findings.

The specific objectives of the assessment were to:

1. Assess the acceptability of technical assistance among MOH staff at national, provincial, district and facility levels;
2. Determine the level of influence on district and facility level activities;
3. Determine the extent to which project intermediate results are achieved; and
4. Understand the major factors influencing the achievement or non-achievement of these results.

The study was conducted in two phases in order to capture two time points of stakeholders' perspectives on MCSP TA. Phase I, conducted in July 2018, provided feedback that was used to adjust and strengthen MCSP implementation. The second phase was conducted in December 2018 as the project was closing out and it informs recommendations for future RMNCAHN program design in Zambia. Phase II data was also used to highlight any changes in stakeholder perspectives across the study objectives over time.

Fig 2. MCSP/Zambia Theory of Change



Methods

Study Design

This study utilized qualitative data collection with complementary analysis of quantitative data from the DHIS2 and MCSP database. MCSP Zambia collected data in two phases (June 2018 and December 2018) approximately six months apart to enable adequate stakeholder interaction with the program and time to implement phase I recommendations. The results from both phases are highlighted in this report.

The qualitative data come from key informant interviews (KIIs) to help capture perceptions, opinions, experiences and recommendations from stakeholders. MCSP interviewed a wide variety of critical stakeholders at national, provincial, district and facility level MOH staff, CoC project staff, other implementing partner staff (SBH, SM360+), and MCSP staff by using a semi-structured interview guide with a mix of open- and close- ended questions. The Program also analyzed MCSP Performance Monitoring Plan (PMP) indicator data that was collected over 12 months through routine program monitoring systems from the national HMIS. The quantitative data was used to determine the extent to which project's intermediate results (IRs) had been achieved.

Sampling

Key informants were sampled purposively from each target stakeholder group within the four supported provinces and at the national level. This approach was taken to ensure representation of MOH colleagues and district/facility level personnel who were the core recipients of the program. Interviews were conducted with 62 (Phase I) and 59 (Phase II) key informants at national, provincial, district and facility levels. Five districts were selected from each of the four provinces, for a total of 20 districts that were randomly sampled from the list of districts that had received CoC funding for at least two months. The study team selected facilities in closest physical proximity to the randomly selected DHO.

The sample included key representatives of all participating groups in each of the sampled districts. The sampling process contributed to the sufficiency of the sample; though purposive, the process utilized elements of:

- Convenience by interviewing participants resident in districts where the MCSP office is located;
- Randomization by systematically choosing every other district from a sampling frame (this random selection excludes the districts where MCSP office is located, as those were already conveniently sampled);
- Variation by including a range of stakeholders with different dimensions of interest; and
- Cost by limiting the number of districts.

From previous experience with similar KIIs, the investigators deemed the sample size sufficient to reach saturation. Table 1 shows the distribution of informants from the four provinces and the national level.

Table 1: Sample Distribution

Phase I								
Province	**MOH-National**	**MOH-Provincial Staff**	**MOH-District Staff**	**MOH-Facility Staff**	**CoC Project Staff**	**Partners (SBH, SM360+)**	**MCSP Staff**	**Total**
Eastern	N/A	1	5	5	0*	2	2	16
Muchinga	N/A	1	5	5	1	1	1	15
Southern	N/A	0*	5	5	1	2	1	16
Luapula	N/A	2	5	5	1	2	1	16
National	2	N/A	N/A	N/A	1	2	0*	7
Total	2	4	20	20	5	9	4	62
Phase II								
Province	**MOH-National**	**MOH-Provincial Staff**	**MOH-District Staff**	**MOH-Facility Staff**	**CoC Project Staff**	**Partners (SBH, SM360+)**	**MCSP Staff**	**Total**
Eastern	N/A	1	5	5	0*	1	2	14
Muchinga	N/A	1	5	5	1	0*	2	14
Southern	N/A	1	5	5	0*	3	2	16
Luapula	N/A	2	4	5	0*	2	2	15
National	0*	N/A	N/A	N/A	0*	0*	0*	0
Total	0	5	19	20	1	6	8	59

*0 means that an interview did not take place.

After sampling was completed, the following participant inclusion and exclusion criteria was applied in order to collect a pool of participants for the study.

Participant Inclusion Criteria:

- MOH/CoC participants who worked in a role that involves overseeing, supervising, supporting or delivering RMNCAHN services
- District level participants from districts that have received CoC funding for at least 2 months
- Other implementing partner participants who worked on RMNCAHN projects in MCSP supported provinces OR in a role that supports CoC program planning, implementation or monitoring
- MCSP staff who have been in the position for 2 or more months

Participant Exclusion Criteria:

- Do not support RMNCAHN services
- Have recently taken post less than 2 months ago
- Unwilling or unable to give informed consent

Data Collection Tools

MCSP developed key informant guides to elicit critical information specific to each informant category (e.g. MOH representatives, partner staff). Three KII guides were designed for this study and are attached at the end of the report in Appendix I.

1. Provincial/District/Facility MOH/CoC Informant KII Guide
2. Implementing Partner Informant KII Guide
3. MCSP Informant KII Guide

Data for quantitative analysis of facility RMNCAHN service delivery outcomes was extracted directly from the national HMIS-DHIS2 as well as the MCSP monitoring database that do not contain individual identifiable information. The data analysis focused mostly on PMP indicators.

Research Ethics Approval and Ethical Considerations

The Johns Hopkins University Institutional Review Board determined that the research plan met the criteria for Non-Human Subjects Research. Ethical approval was obtained from ERES Converge (a local ethics committee in Zambia) as well as from the National Health Research Authority in Zambia.

Data Collection, Processing and Analysis

Personnel & Training

The MCSP Zambia Provincial Monitoring, Evaluation, and Research (MER) Officers and Technical Officers/Advisors underwent a two day data collectors training, which included ethics orientation, interview skills role-play and tools pre-testing prior to commencing fieldwork.

Interviews & Transcripts

In each phase, data collection was conducted within a one-month period by a team of two per province. Teams conducted interviews in provinces that were different from their normal base of operation in order to reduce interviewer bias (discussed further in Limitations section below). All interviews were recorded and subsequently transcribed. Interview transcripts were assigned unique identification codes to assist in retrieval and ongoing analysis.

Content Analysis

Data analysis of the qualitative interviews was based on content analysis focused on pre-determined themes and sub-themes associated with the evaluation objectives; emerging themes were compared, combined and incorporated.

Pre-determined Analysis Themes

Study Objective 1: Assess the acceptability of technical assistance among MOH staff at national, provincial, district and facility levels

- Awareness of the MCSP and its relationship to the CoC/G2G grants among key government counterparts
- Key areas of TA support (planning, implementation or monitoring) received from MCSP
- Relationship between MCSP and CoC project staff /other implementing partners (SBH,SM360+)

Study Objective 2: Determine the level of influence on district and facility level activities

- Key areas of TA support (planning, implementation or monitoring) received from MCSP
- Unmet MOH TA needs applicable to this type of support

Study Objective 3: Determine the extent to which project intermediate results are achieved

- Perception of HCWs skills
- Scale-up of high impact RMNCAHN interventions
- Improved community engagement systems

Study Objective 4: Understand the major factors influencing the achievement or non-achievement of these results

- Challenges/gaps experienced by MOH in receiving the TA
- Recommendations to improve TA model
- Successes achieved through the utilization of this model
- Challenges faced, gaps identified and lessons learned in implementing the TA model by MCSP staff

Study Limitations

MCSP Monitoring, Evaluation and Learning (MEL) Officers and Technical Officers/Advisors served as data collectors and conducted the interviews with key informants. The use of program personnel could potentially introduce interviewer and interviewee bias as MCSP staff interviewers may subconsciously influence the subject into giving skewed answers and they may also have relationships with informants that may prevent the subjects being objective and candid. To address this, interviewers were assigned to different provinces than their base of operation where they were unfamiliar with the informants. The convenient sampling of interviewing participant's resident in districts where MCSP office is located has high potential of bias as these are districts more likely to know more about MCSP. The proposed sample in the study protocol of 70 key informants could not be achieved due to non-availability of some key personnel; the response rate was 86%. During phase II data collection, national level respondents could not be interviewed due to other commitments. Finally, the assessment did not include donors supporting the COC program (e.g USAID, SIDA and DFID) as key informants, but this would have provided a useful perspective.

Results and Discussion

This section presents a synthesis of findings from the qualitative key informant interviews conducted at national, provincial, district and facility level with findings organized by study objective. The boxes include representative quotes from the key informant interviews. The findings from the secondary analysis of routine project data were categorized under study objective 3 (determine the extent to which project intermediate results are achieved).

Study Objective 1: Acceptance of Technical Assistance among MOH Staff, CoC Staff and Partners

The study evaluated the acceptability of the MCSP technical assistance among MOH staff at different levels based on the following variables: awareness of the project; accurate knowledge of the project objectives and activities; and reported interaction and experience of the informant with project activities and personnel. Most respondents at the national, provincial and district level were aware of MCSP. They were also able to correctly describe the project objectives, core activities, MCSP's relationship with the CoC, and how they or their supervisees interacted with the project.

In phase I, only 75% of facility level informants were aware of MCSP and 25% had no knowledge of any relationship between MCSP and the CoC. Phase II results showed similar patterns with good levels of awareness among stakeholders across all levels, with a specific improvement in awareness among facility level informants. Over 90% of facility informants were aware of the project and able to describe the role of the project. In phase II interviews, most facility level informants associated the project with specific interventions as opposed to just indicating that the project provided TA and was funded by USAID. They described MCSP as a program that supports facilities with mentorship, capacity building of communities and supporting mother and child health initiatives.

Technical Support Received

- "…Providing TA to do with G2G funding; support districts to come up with high impact interventions. Analyzed the results/data with MCSP together and it was helpful in coming up with that plan…" MoH district staff
- "MCSP has provided SQA to our facilities, and MCSP was the first one to show us how to use the SQA, MCSP also provided guidance in EPI, infection prevention, and the set-up of the clinic" MOH district staff

The specificity and depth of the description indicates first-hand knowledge and increased interaction of facility level personnel with MCSP which points toward increasing acceptance of MCSP's TA role. These results also reflect how MCSP got introduced to MOH and partners at the national and subnational levels and the approach it used to providing TA. During phase 1, staff at the health facility knew little about MCSP since at inception the Project interacted primarily with the national, provincial and district level personnel. The fact that the Project began implementation long after the G2G Program and that the DHO level was the target of TA made it more difficult for the lower level staff to get a full understanding of the Project and its design. Between phases 1 and 2, MCSP made very deliberate efforts to introduce and describe itself to all staff at any opportunity. To improve recognition of such a TA mechanism the ideal setting would have been to have the donor align the Project's inception with the G2G Program. Increased interaction between MCSP staff and health facility staff improved the knowledge about the project.

Understanding MCSP

"MCSP is a USAID funded project supporting the RMNCAHN CoC by providing demand driven TA in four provinces." – MOH national staff

"MCSP supports services that target improvement of maternal health, child survival and my role looks at these areas on a daily basis…All the work MCSP is working on is a function of reproductive and maternal health and nutrition" – MOH provincial staff

Several facility level participants, however, did not articulate the link between MCSP and the CoC. The project team believed this knowledge gap existed because of the project's focus on district. This finding is in line with MCSP's project design to provide TA to DHO staff who would then cascade that TA to the health facility level in an ongoing manner that would outlive the project thereby promoting ownership and sustainability.

The CoC and other implementing partner respondents were able to describe their day-to-day working relationships with MCSP by explaining how MCSP's role fits with theirs, which most characterized as complementary and synergistic rather than duplicative. Informants mentioned participating in joint field trips with MCSP to districts and facilities to review performance, identify gaps and provide support including mentorship. Partners also worked together during the midterm expenditure framework (MTEF) planning, as they jointly supported the districts to develop annual CoC plans. The level of collaboration noted here is indicative of the acceptance of MCSPs TA support among CoC personnel and partners.

Clear Delineation of Partner Roles

"There is a very strong relationship; we are both TA partners under the RMNCAHN program. MCSP is more on the implementation of the program and SBH is focusing on the systems, we are trying to strengthens, so for MCSP to work well the systems needs to be strong…"SBH staff

Overall, there was good acceptance of the project by the MOH and partner personnel who were aware of the project; however increasing the visibility and branding of the project as TA for the CoC was important to ensure seamless integration and complete harmonization with the G2G grant implementation processes.

Study Objective 2: Influence on Planning and Implementation of District and Facility Level Activities

The level of influence on district and facility level activities relied heavily on the ability of MCSP to engage the districts during the planning process and to ensure that high impact interventions (HIIs) were included in the plans and implemented. MCSP supported 42 districts in the development of their 2018 and 2019 district plans. MCSP TA focused on helping districts assess their performance based on the key RMNCAHN indicators, scorecards, performance assessment reports, district integrated meeting reports, and DHIS2 data.

Most districts indicated that the TA helped identify and prioritize which HIIs to include in district plans and budgets. Informants from the four Provinces also reported receiving MCSP TA that included capacity building in Service Quality Assessments (SQA), mentorship, Medium Term Expenditure Framework (MTEF) and other planning exercises. At the national level, MCSP focused on sharing the key RMNCAHN program delivery findings and recommendations from the districts and conducting joint support visits with the national level MOH staff. MCSP also participated in the launch of the planning activities at national level. These national level activities were expected to strengthen policy and program decisions at national level. In both phases of the study, national level informants indicated that while they were aware of MCSP's activities and progress at the provincial and district levels, they would have appreciated increased support and engagement at the national level. The design of the MCSP TA model placed 80% of implementation at the district level and below and as a result, the project focused more on district and facility level support and less on national level engagement.

In phase II, findings related to technical assistance received by MOH informants was similar to phase I findings at the district and province levels. All district and most provincial level informants reported that MCSP's support remained consistent and effective. However, two strategies featured more prominently in phase II results than in phase I: the use of mentorship scorecards and health facility visits. MCSP intensified

the frequency of health facility visits and promoted the use of mentorship scorecards in the final six months of the program in order to consolidate gains in health care workers' skills and quality of care.

Technical Support Received

"Mentorship…..traditionally was only concentrating on labor and delivery, but with the coming of MCSP, child health has also been integrated (EPI & IMCI). We have also seen dashboards displayed after mentorship" MCSP Staff

"Use of the scorecard which looks at the performance of certain indicators for easy identification of areas of improvement" MOH District

"Mentorship dashboard have made it possible to interact with the mentees directly and able to grade the mentee for onward course of action" MOH District

"SQA, this is a government tool which MoH was not using but MCSP made sure that the ministry begun using this tool. This has helped facilities/districts identify gaps and come up with ways to address them" MCSP Staff

Study Objective 3: Achievement of Project Intermediate Results

MCSP in its theory of change (ToC) (Figure 2) identified three critical intermediate results, or outcomes, integral to achieve the project's goal and objectives:

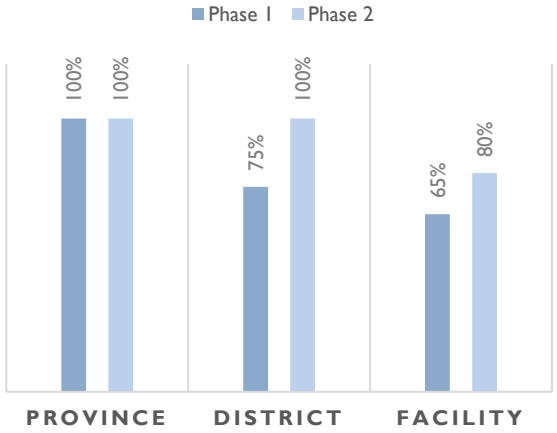
- IR 1.1. High Impact Interventions (HIIs) Implemented
- IR 2.1. Health Worker Skills Improved
- IR 3.1. Community Engagement Systems Strengthened

All study interviews included questions on each of these result areas in order to obtain stakeholders' perceptions on the achievement of these results.

IR 1.1. High Impact Interventions Implemented

Overall, a majority of respondents from both phases indicated that MCSP's TA described the detailed recommendations, follow-up processes, and continuous technical support provided by MCSP, which helped them plan and implement priority high impact interventions. Figure 5 shows the percentage of informants who agreed that MCSP TA enabled them to implement high impact interventions from the four provinces – increasing by 25% (district) and 15% (facility) between the two phases. Facility level informants described the following as types of support, which are similar to the TA provided during the program:

Figure 5: TA has enabled implementation of hii



- Defaulter tracing for babies to improve immunization rates and reduce drop-outs
- Mentorship on newborn resuscitation leading to reduction in neonatal deaths
- Improvements in immunization outreach services and coverage;
- Improvements in post-natal care

District level informants mentioned:

- Improved RED plans
- Improved quality of ANC and PNC, reduced referral due to improved EmONC capacity,
- More regular Maternal Deaths Reviews
- Improved capacity to implement ASRH services

Quotes describing HII outcomes:

Maternal Health

- "During planning, we received high impact interventions from MCSP, which improved the RMNCAH&N indicators. E.g. the domiciliary visits in the communities using the SMAGs. Postnatal coverage increased from 60% to 90%'" -MOH facility staff
- "MCSP TA enabled the districts implement maternal deaths reviews in a systematic way and facilities have reduced on maternal deaths in the first two quarters of 2018" -MOH facility staff
- "MCSP TA helped develop high impact interventions for the 2018 & 2019 G2G plans e.g. facilities were trained in EmONC, and those facilities are no longer referring to higher- hospitals. Partographs are reviewed and well filled." -MOH District staff
- "Early referrals to reduce maternal deaths resulting in a maximum of 3 maternal deaths this year which are far less than 2016 and 2017; before the TA, Early ANC book was at 8% but is now at 30%, facilities are now able to measure height for age which was not done before MCSP came on board and stunted children are being referred to the hospital' -MOH facility Staff
- "We've seen some significant improvement in some indicators, for instance early antenatal booking before 14 weeks we were around 2% and went to 5% and now we are around 15%." -MOH District Staff

Newborn Health

- "Staff are now able to use equipment after mentorship such as penguin suckers leading to reduction in neonatal deaths and fresh stillbirths." MOH facility staff

Child Health

- 'MCSP TA provided to open up more outreach posts which enabled the district to improve on immunizations and fully immunized" MOH facility staff
- "During the TA for example, using the community registers on how to track babies not coming for immunizations (defaulter tracing) was emphasized and has been implemented. This has resulted in higher immunization rate and the dropout rate has reduced." MOH facility staff

Adolescent Health

- "The district was struggling to come up with an Adolescent TWG but now because of MCSP, the district has an active Adolescent TWG and Youth friendly spaces" MOH District Staff"
- "MCSP provided TA on ASRH and the district was mentored on appropriate interventions on Adolescent Health and we have rolled it out after we did a training and we are doing continuous mentorship for the same. The facilities we trained all have Adolescent Heath spaces. We trained 38 facilities and gave them manuals for implementation for ASRH services." MOH District staff

Nutrition

- "GMP has greatly improved by identifying the malnourished children. Reduction of the infection prevention in the labor ward to improve quality of service" MOH facility staff

Community Engagement

- "We were also able to procure commodities for outreach service meetings with SMAGS." MOH facility Staff
- "The engagement of headmen to push the communities/women to bring children for 1st postnatal care and immunization has also contributed to improved RMNCAH&N indicators. Referrals are being made in good time and transport is now available." MOH facility Staff

Improved Planning

- "The TA helped the program officers to stop thinking the usual way but think logically when planning for activities e.g. inputs, outputs and outcomes. The picking interventions of interventions was based on data."MOH Provincial staff
- "MCSP made sure the trainings were reduced and more focus was placed on mentorship". MOH Provincial Staff

Analysis of PMP Outcome Indicators for High Impact Interventions

Figure 6: 1st ANC

MCSP supported districts to integrate ANC during outreach services to improve accessibility and coverage as well as implement mentorship activities for SMAGs, CBV, and HCWs. The proportion of pregnant women who received antenatal care (ANC) in their first trimester increased from 15% in 2017 to 29% in 2018, surpassing the MCSP set target of 25%.

Figure 6: Percentage of pregnant women who received 1st ANC before 14 by Province 2017- 2018

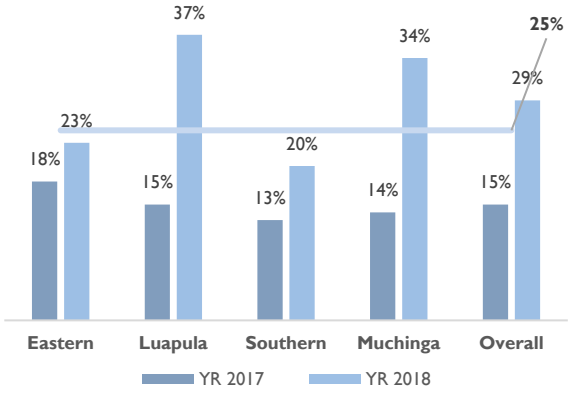


Figure 7: 4 ANC Visits

The proportion of pregnant women who have received at least four ANC visits increased by 13% (from 34% in 2017 to 47% in 2018) in one year, also surpassing the MCSP set target of 42%. Eastern and Southern Province recorded the highest increases, which can be attributed to the integration of ANC during outreach services as well as use of mentorship to SMAGs, CBV, and HCWs in demand creation. To facilitate integration, the MCSP team also oriented HCWs and CBVs in the 2016 WHO ANC guidelines and recommendations including the focus at 8 contacts. Strengthening integration of ANC and other key services is key in reaching more women with key interventions.

Figure 7: At least 4 ANC Visist by Province 2017 and 2018

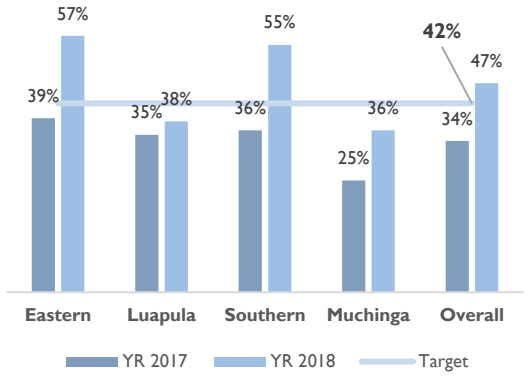


Figure 8: Institutional Deliveries

The proportion of pregnant women delivering in facilities increased across all four provinces, reaching the MCSP target of 71%. MCSP supported multiple strategies to influence the institutional delivery rate, including community sensitization, engagement of SMAGs and traditional leaders. The Program also increased the availability of mother's shelters and established additional maternity units at existing facilities to increase availability of maternity care services.

Figure 8: Percentage of institutional deliveries by Province FY2017 & FY 2018

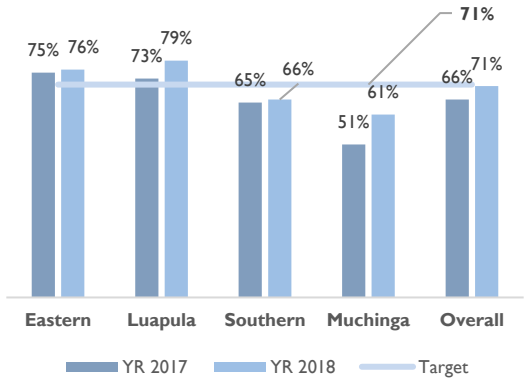


Figure 9: Diarrhea non-bloody Incidence under 5 years

The target was to reduce incidence of diarrhea from 284 in 2017 to 271 by 2018 in the four provinces however, only Eastern, Luapula and Muchinga recorded slight reduction while Southern recorded an increase in the number of cases. MCSP therefore offered mentorship and orientation to IMCI tools to strengthen the IMCI program in Luapula, Muchinga, Southern and Eastern Provinces.

Figure 9: Incidence of Diarrhoea non-bloody cases under 5 years by Province

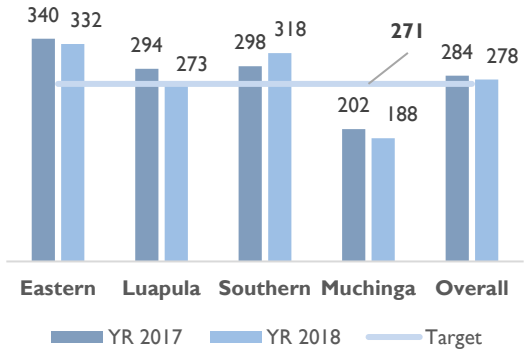


Fig 11: Postnatal Care Visit within 6 days

The proportion of women going for postnatal care visit within 6 days reduced to 41% in 2018 from 48% in 2017. In Eastern province, MCSP supported the DNOs and HF HCWs to intensify sensitization to mothers on the importance of postnatal within 48hrs, and encouraged home visits by facility HCWs. MCSP also encouraged linking mothers to SMAG members who would then remind them when their postnatal was due.

Figure 11: Percentage of Postnatal Care Visit within 6 days- in MCSP Supported Provinces FY2017- FY2018

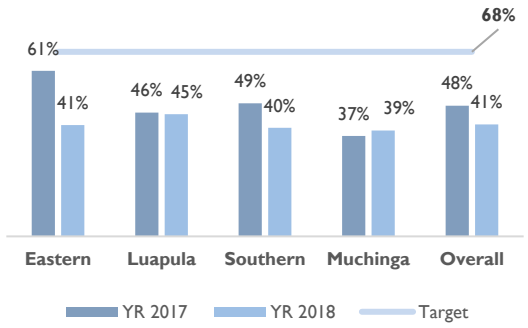


Fig 12: U5 Underweight

Overall proportion of underweight children has slightly reduced from 0.27% in 2017 to 0.26% in 2018, below the target of 0.2%. Luapula recorded still had a major decline while Southern Province recorded an increase in underweight children.

Figure 12: Percentage of children underweight < 5 years by Province

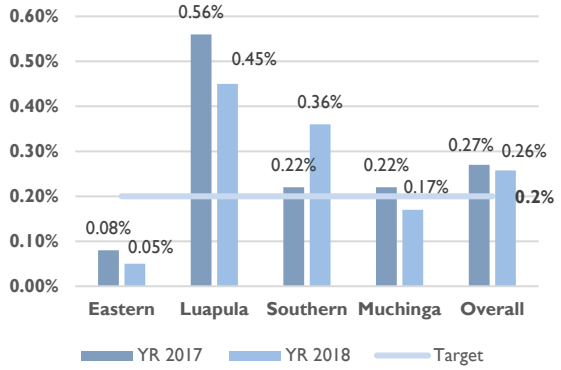
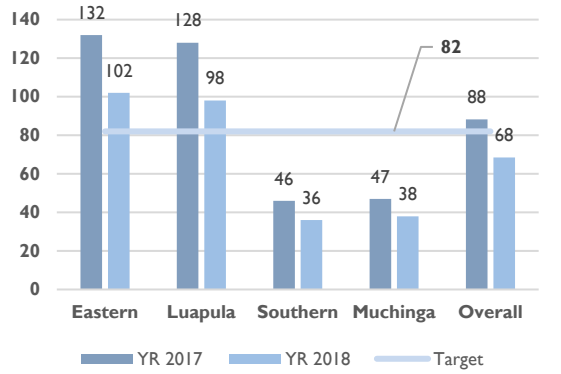


Fig 13: Incidence of Pneumonia cases under 5 years

Overall the incidence of pneumonia cases for under 5 children reduced from 88 in 2017 to 68 in 2018, surpassing the target of 82. Eastern and Luapula has high incidence of pneumonia under 5, but recorded a big decline. MCSP believes that community engagement activities contributed to the improvements seen here.

Figure 13: Incidence of Pneumonia cases under 5 years



IR 2.1. Health Worker Skills Improved

MCSP improved health workers' clinical, planning, quality improvement, and data use skills. The Program helped 42 districts create or strengthen existing clinical mentorship systems that provided on-site and team-based support to facility based providers. In 50% of the 42 districts, MCSP assisted in the establishment of multidisciplinary mentorship teams. This involved provision of support during planning and scheduling of activities to develop the mentorship teams according to national guidelines using the G2G grants. In the other 21 districts, MCSP strengthened already existing mentorship systems by expanding the clinical content covered during mentorship visits.

Figure 15: Respondents Reporting Improved HCWS Skills

The majority of the provincial and district informants in Eastern, Muchinga and Luapula reported that MCSP TA improved the HCWs skills through TA in mentorship, SQA, and planning. These informants reported improvements in non-clinical skills including community engagement, planning, data management, data use and use of scorecards. Sixty percent of the informants in Southern Province, comprising of provincial, district and facility level informants, reported that MCSP's TA had not improved HCWs skills because of the limited period the districts have worked with MCSP. However, the majority of facility level informants in all provinces reported that TA contributed to the HCWs skills (see Fig. 4), and in particular clinical service delivery skills such as: use of partographs, successful resuscitation of babies, integrated management of childhood illness (IMCI) skills, and calculation of immunization dropout rates.

In phase II, over 85% of informants at all levels reported improved health worker skills as a result of MCSP's support (Figure 15). MOH facility informants reported reductions in maternal, neonatal and stillbirths which they attributed to improved neonatal resuscitation skills, improved use of partographs and the ability to identify and refer complications earlier. At district level, informants reported improved mentorship skills especially the use of scorecards to record and follow up on mentorship activities; improved data collection from facilities as a result of data management mentorship; ability of district personnel to conduct SQAs independently, improved RED strategy planning, and ability to update immunization monitoring charts correctly.

HCW skill improvement resulted not only from MCSP's direct mentorship but from cascaded mentorship by the integrated district mentorship teams suggesting that onsite mentorship by MOH staff is a sustainable intervention to propel Zambia towards self-reliance.

Quotes describing Improved Health Worker Skills:

Facility Level
"Immunization Monitoring Charts are now well updated by staff and staff are now aware of IMCI guidelines and use them when screening children."

"When the Under-five registers were initially deployed, our HCWs did not understand how to update them. However, after the orientation and mentorship, they are now skilled and data entry has improved."

"Because of the TA, there has been notable improvement in the proper filling in of registers by the MHC staff, attending to mothers, attending to emergences like PPH postpartum hemorrhage and helping babies to breath."

District & Provincial Level Quotes
"There has been skills transfer when the HCWs are visited by the mentor-ship team from the district office and there has been tremendous improvement in service delivery in general and a reduction in the number of referrals compared to the past. Unnecessary referrals are no longer taking place because they can be managed at the point of service delivery."

"Our staff have improved their skills in the labor ward through mentorship. Neonatal resuscitation skills have also improved and neonatal deaths have reduced. There has also been an improvement in the use of the partographs in the labor ward."

"RED strategy planning was a challenge for most of the facility staff but after the onsite Technical Assistance, they were able to conceptualize, develop and submit the plans."

"Initially, SQA was not appreciated by districts when MCSP started implementing the TA model, however after seeing the need and how it helped to identify gaps during planning, districts are able to appreciate the SQA."

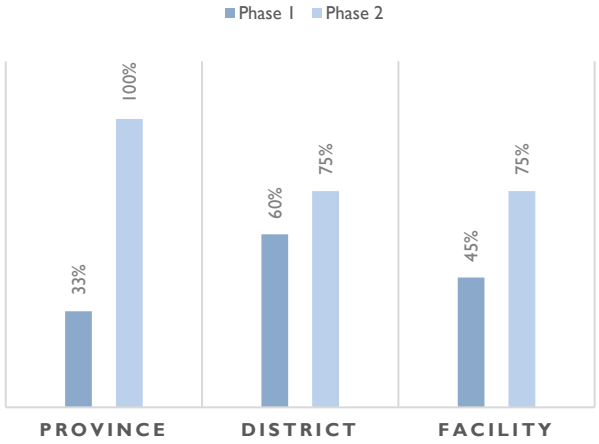
"Our mentorship approach has also improved as a result of the TA. We also now make use of the dashboards and this has made mentees appreciate data and the role it plays in showing them where the gaps in performance are."

"Where we previously used to record completeness of 80 and the like we now speak of 90 and 100 percent in certain areas we've had a lot of improvement those there is still room to do more, with continued TA we would have done much more."

IR 3.1. Community Engagement Systems Strengthened

The project aimed to strengthen community engagement systems by orienting DHOs on high-impact community engagement strategies, including strengthening community health platforms. MCSP identified and formally designated District Health Promotions Team (DHPT) representatives including private sector and civil society organization (CSO) partners in 24 District Health Offices (DHOs). Additionally, 269 of 294 district personnel along with 564 of 1009 targeted facility personnel were oriented on community engagement approaches. Despite these successes, the project team recognized the missed opportunity at the beginning of MCSP to incorporate community engagement and ASRH mentorship into district teams. Figure 7 shows the results of how informants viewed MCSP's TA in Community Engagement at the province, district, and at the facility level.

Figure 16: TA Improved Community Engagement System



In phase I, the majority of informants at the provincial level reported that MCSP's TA did not improve community engagement systems except in Luapula province. At the district level 60% of the informants across the four provinces agreed that MCSP's TA improved community engagement systems. At the facility level, the majority of informants in Muchinga and Southern province reported that MCSP improved community engagement and cited key initiatives, such as focus on improving community structures, incorporating gatekeepers, supporting stakeholder analysis, and support from other local NGOs. In Eastern and Luapula provinces, some facility level informants reported that TA on community engagement activities were non-existent and communities were not engaged. This was because TA focused on strengthening district level systems and health facility support, with limited community level support. This was due to the initial focus on strengthening access to quality services at the start of the project as well as the TA cascade process with MCSP strengthening the district health office teams and the districts working with facilities and communities.

This assessment documented improvements in community engagement in all provinces and at all levels, with 75% of informants at facility level reporting improvements in Phase 2. Informants reported increasing engagement with community volunteers to implement strategies towards the reduction in immunization dropout rates, reviews of maternal deaths with community groups, trainings and orientations to strengthen existing community based teams, use of data to lobby for increased community participation and TA for improved messaging for community sensitization. There were however a few informants who asserted that there had been no improvements and they suggested supporting initiatives to motivate SMAGs, others said there was too much focus on health facility staff and that community personnel were neglected.

Quotes describing Improved Community Engagement Systems:

District Level

"Because the TA they are giving is mainly to health care workers. It has not gone to that level to involve the community"

"…The improved community engagement has translated into the increment in FP acceptors, institutional deliveries and no maternal deaths."

"TA did improve Community engagement systems quite a bit. Prior to the time we met with MCSP, the district did not really have a robust form of CE system, but after sitting down with MCSP and the TA received, our plans started reflecting a larger component of CE without which we cannot achieve much."

Facility Level
"…We were able to effectively engage the community because of the TA we have received."

"Through the knowledge given by MCSP during TA, we have been able to make our Neighborhood Health Committees active."

"The main community sensitization systems we been using are radio sensitization and community meetings at facility level. When we had that TA, we were assisted we able to come up with better messages and rather more efficient ways of delivering those messages."

Personal Level
"MCSP has helped come up with community based structures and community engagement has been emphasized with facility staff."

"However, we had limited time with the MCSP officers who were handling this. We are yet to see if the strategies shared will work."

Study Objective 4: Factors Associated with the Success or Failure of the Model

Factors associated with the success or failure of the TA model were elicited through questions on current challenges with the technical assistance delivery and recommendations to improve the technical assistance model.

1. Understanding MCSP's TA role for the CoC

While understanding of MCSP's objectives and purpose improved over time, expectations of direct facility level support (as is provided by all other implementing partners) still lingered among both facility and district level staff. Informants also described the time gap between the initiation of the CoC program, the 2018 district planning process, and the introduction of MCSP as part of the CoC program. Many districts found it challenging to sync the two programs and had an expectation that, like other programs, MCSP was bringing in additional funds to support facility level implementation.

"….I think the model itself we did not quite understand it, because the technical support we've been receiving has always been accompanied with funding when you identify a gap so the earlier thought was that there will be some kind of funds to bridge the gap but that money sat in the CoC grant but the challenge was that the grants were developed much earlier so it was only at review times that we could incorporate certain things that were recommended and so you could find there is a recommendation but there is no funds to deal with that recommendation until you vary those funds at the time of review…." MOH Province

- Complexity of Coordination at PHO and DHO level

In phase I, national level informants reported weak coordination of the CoC program in Muchinga, Southern and Eastern provinces with partners, including MCSP. Provincial and district leadership had to support and coordinate with multiple implementing partners which had overlapping and/or complementary activities.

"As Chipata, we are blessed because MCSP is now within our offices, and this has made it easier for MCSP to provide TA, we therefore request that MCSP has a staff located at all districts for easy access" MOH- District Level

- Inadequate resources for province wide Technical Assistance

MCSP was designed to provide 80% of its support at district and facility/community levels with only 20% of its support at provincial and national level. In phase I, over 80% of informants at all levels reported not having any challenges receiving technical assistance. In phase II, 20% facility informants and 47% districts level staff from the 4 provinces indicated that they experienced challenges in receiving technical support from MCSP in the last 6 months. The challenges experienced according to MOH informants ranged from inadequate number of TA visits, inadequate numbers of MCSP staff to support districts, inability of districts to sustain initiatives introduced by MCSP due to funding availability timelines and unmet requests for increased facility level support from MCSP.

"The fact that support was being done at District level, expecting that the district would go on the ground to implement at facility level but due to resource constraints, the districts would not have done as effectively as they anticipated." MOH District

District level informants reported an inadequacy of TA visits especially the length of time and the frequency of the visits. This was described in MCSP staff interviews as the result of inadequate numbers of staff to support all the 44 districts across the four provinces as well as logistics limitations with project transportation resources.

- Technical Assistance without Implementation Funding

Under this TA model, resources were going directly to the districts and MCSP was not funding activities. National level informants did not view this as a challenge because this approach of sending funding directly to the districts and supported to plan and implement helps build the district's capacity to manage resources – one of the CoC program objectives. Informants believed that this approach was aligned with the government's approach of sending resources directly to the districts from the central government; except the CoC program had donor funds that were transferred to and implemented through government structures.

"In terms of direct funding to districts and MCSP going to provide TA, this is a good model, the only gap is the communication to indicate the gaps identified and the support to be provided. The collaboration between the central level and MCSP. Even from central government, resources go direct to the districts and this has improved service delivery.

At the sub-national level, the absence of funds to support activities by MCSP was not seen as a challenge by some informants who understood the role of MCSP especially in Muchinga, Luapula and Southern provinces at phase I. Informants said MCSP's TA objectives were clear and they understood that this TA would support them in implementing the activities planned with CoC funds. They also mentioned that a number of TA activities did not require funding, such as sharing best practices and onsite support. In Eastern province however, 60% of district and facility level informants indicated

"They do not fund on their own to make a program so that we can incorporate in our plan. They depend on funds that we already have as a district and that poses a challenge in their logistical management. It would be better for them to have a bit of funds to support certain programs" MOH Stakeholder

"We would have loved MCSP as well despite offering technical assistance to also have a small resource that could be used by the district in an event there is an urgent need or a bit of contingent which can be used to support the district" MOH Stakeholder

that direct funding from MCSP was important in order to effectively support implementation of certain activities resulting from TA and to motivate staff.

In phase II, a handful of informants still requested that MCSP needed to support some level of direct implementation at facility level. However a greater proportion of informants reported a need for direct funding from MCSP: 75% of facility level staff, 68% of district staff and 50% of provincial staff indicated that it was a challenge that MCSP was not directly funding activities because some districts had needs that were not covered by other resources, TA on some gaps identified could not be implemented due to lack of funds while others just had a misunderstanding about the role of MCSP.

"The partnership can be made more effective if we can also have staff from MCSP who are also directly implementing activities at facility level." " MOH Facility

"…It could be a good thing if resources were also given to MCSP to implement activities at that level instead of just TA support because as much as we want to rely on the SIDA funding, SIDA funding is not sufficient to cater for all the activities… MOH District

"…There are times we go in the field with MCSP, they identify gaps but cannot do much about them because they are not the ones providing the resources …" MOH Province

- Late Engagement with the 2017 Mid-term Expenditure Framework (MTEF) Planning

Providing TA to districts during the MTEF pre-planning phase provided an optimum opportunity for the districts to utilize data to identify the most responsive evidence-based HIIs for each specific district and province. These interventions are then incorporated into the district and provincial plans during the actual MTEF planning process. MCSP's did not manage to provide TA during the 2017 MTEF preplanning and planning processes for the 2018 plans since it was in its start-up phase at the time. The Project however contributed to revision of these plans providing TA to the districts and provinces to refine them. This involved participation in review and ad-hoc re-planning meetings that involved traveling to districts to review the data, identify the appropriate HIIs before the main planning meeting involving the national level team. Revision of the plan was not the most optimum time for the Project to influence inclusion of evidence-based priority HIIs into all provincial and district plans.

- Complimentary and joint TA implementation

Partner informants described with specific examples how they have worked closely with MCSP jointly implementing complementary technical assistance activities. For example, MCSP supported orientations of SM360+ trained district mentors on the use of mentorship dashboards to track mentee progression. Another example was support for CoC planning where MCSP guided the districts on interventions/technical content to prioritize while SBH supported the planning systems and processes. Informants also mentioned joint MDSR meeting support.

"We had agreed to be meeting on a weekly basis to share our plans but that has not been possible because of different schedules, thus we end up meeting on a monthly basis instead" Partner

"We planned to be having weekly meetings to enable us share updates, work together and avoid duplication in our work." Partner

- Co-location with other TA partner

Partner informants indicated that sharing offices strengthened relationships and collaboration between the projects in the overlapping provinces and districts.

- Timely CoC funds disbursements

Informants also described the delays in CoC funds disbursement as a factor affecting the effective receipt of technical assistance from MCSP. Timely disbursement helped to ensure procurement required equipment and materials and joint planning with MCSP.

"Relationship building with other partners is important to the successful implementation of the project. Different partners have different ways of working which has the potential to affect the implementation of activities as we all target the same people, hence ensuring a good working relationship and harmonized approach with partners is key." MCSP staff

"The disbursement of funds to the provinces must be timely so that procurements can be done in good time. This will also make it easier for us to work together in providing TA because everything needed would be in place." MCSP staff

- Teams visits and joint partner support visits to districts and facilities

Interviews with the MCSP team reported the need to maximize resources especially time. Due to competing activities in the districts, it is recommended to conduct joint support activities with other partners in the provinces and to develop joint support schedules. The team also recommended providing TA visits as a team as opposed to different technical advisors scheduling different visits at different times to enable maximum attention of the district personnel.

- Increased presence and collaboration at district and facility level

MCSP informants recommended increased staffing levels and frequency of TA visits at facility and district level to improve visibility and clarity of the roles of the project thereby increasing access to MCSPs TA for districts across the provinces.

- Harnessing authority of the provincial health offices

MCSP informants also recommended working closely with provincial focal points ensuring their involvement in TA activities to promote sustainability of new initiatives with Provincial health office focal point accountable for follow up of TA recommendations made in previous visits.

"As a TA partner we need to be so much on the ground, for example, in Chienge it is difficult to provide demand-driven TA because of the distance from Mansa, thus it would be good for TA partners to be close to districts. There should be a lot of collaboration at province, district and facility level so that everyone understands that MCSP does not provide direct funds" MCSP staff

"Together, we helped the districts to refine their plans and we refined the 2018 CoC plans for the districts to focus on the gaps that were there. We used the RMNCAHN scorecard to pick those gaps." Partner staff"

"Sharing the same office with MCSP is a good idea." Partner Staff

"Another lesson is that, in the districts there a lot of competing activities so you have to negotiate with them and fit in their program"

Conclusion

MCSP's TA model, which seeks to influence government-led planning and implementation, has the potential to be an effective investment in strengthening the health system across all levels. This assessment presents important lessons learned and considerations for future programs seeking to replicate or refine this TA model of support. The MOH and partner personnel at different levels appreciated the role that the TA played in improving various RMNCAHN indicators. Also, while this assessment did not target donor representatives as key informants, ongoing conversations during site visits, planning and budgeting and during review of district plans indicated that the donors acknowledged the value the MCSP's TA added to budgeting, planning, implementation and monitoring of activities. Regular CoC Partners' meetings in Lusaka also provided another opportunity for MCSP to share with the donors, the National CoC Coordinator and other implementing partners, its experiences while providing TA and the achievements that provinces and districts were making as a result of the TA. There was acceptance of MCSP's design for TA at the national level MOH, which shows a potential paradigm shift by government to accept programs which do not come with resources for direct service delivery. This approach therefore, is a promising approach to support countries on the path to self-reliance and in particular, sustainable gains in maternal and child survival.

The success of this model is dependent on multiple factors, including: 1) ensuring that partner roles are clearly agreed upon during start-up and communicated to stakeholders across all levels of the system; 2) engagement in collaborative processes that enabled joint planning; 3) ongoing and consistent implementation support at district levels that built DHO's trust in MCSP as valued advisors and facilitated MCSP's influence on HIIs taken up by the DHOs; and 4) strengthening capacity at subnational levels with skills to identify the gaps, plan and implement targeted high impact interventions.

Recommendations

Following the analysis of the results of this assessment, MCSP has the following recommendations for the MOH and future programs:

Program Visibility, Coordination and Planning

- Orientation of programs to districts and facility personnel should be conducted jointly with national level team before implementation to ensure clarity on the role of the TA to be provided and the full scope of the program.
- To improve recognition of TA mechanisms, donors should align the start of a new program with the G2G Program.
- Implementing partners should share work plan and budgets with MOH at national and ensure areas of support are clearly aligned to the national plans. This helps in allocation and distribution of resources. MCSP recommends that future similar programs are awarded as one program in order to address these issues
- Implementing partners should share reports and ensure consistent engagement with national level counterparts to review performance and agree on areas that require national level support.

- There is a need to strengthen the national level CoC coordination team to facilitate oversight and ownership by the MOH.
- Implementing partners should fully participate in the national level MTEF planning to ensure effective coordination and support. MCSP learned from the first year's late entry into the planning phase to influence the districts to begin putting together HIIs that would go into the 2019 MTEF plans in advance of the actual MTEF planning timelines thereby improving the quality of the 2019 plans.
- MCSP recommends continued engagement of key partners at district and facility level in identifying the key priority areas and designing the model of delivery.
- To ensure effective coordination and support of the districts in identifying gaps, implementation of recommendations, MCSP recommends that TA partners are located at the district health office. This will allow them to participate in all meetings, identification of solutions and timely providing support to the districts and facilities. This will also increase collaboration between TA partners and responsible staff in the districts and facilities, promote ownership of activities and appreciation of TA by district staff.
- To support effective coordination of the TA at the districts and facilities, MCSP recommends that development of a schedule for TA is done together with the province and districts. This will help prevent conflicts in support visits to districts and facilities, especially considering that districts have other partners. This should include joint identification and prioritization of the focus of TA by reviewing of data to identify and agree on the areas of focus for the TA must be conducted jointly with the districts and the facilities.
- Sharing of the findings among the key players such as PHO, DHO, SBH etc. is key to timely support to the districts. Although the provinces and districts have planned meeting such as district integrated meetings, data review meetings, these activities are expensive and inconsistent. However, MCSP recommends that key people based at the district and province meet on a monthly basis to review the performance of districts, it will help in ensuring key recommendations/actions are implemented thereby improving the service delivery.
- MPSP recommends that a standard reporting tool is developed for all partners at the district level to help in coordination.

TA Resources

- MCSP found that not all technical staff knew everything in all the thematic areas thereby making other areas suffer. MCSP recommends that during future TA programs, during every TA visit the necessary multidisciplinary skilled staff to cater for all RMNCAHN thematic areas. MCSP also recommends that future TA programs use senior level staff to provide TA for it to be accepted by the provincial and district staff. Additionally, the Senior Advisors at National Level should have held initial orientations with the project officers to ensure oversight and high level capacity.
- MCSP recommends that a future program increases coverage for TA to facilities and increases the frequency and time spent during TA visits. There are more gaps in facilities and communities that require more support if RMNCAHN indicators will change. MCSP supported the districts with tools like SQA, mentorship to help them address the gaps in facilities and communities, however, it was not possible for the district health staff to attend to the gaps in all facilities due to low staffing levels.

Funding

- Future disbursement of resources should be timely by funders and according to the approved plans is key to ensuring timely implementation of activities.
- A number of gaps identified may require financial support to be addressed such as trainings, procuring of job aids etc., and would ideally be provided by the technical assistance partner without having to wait for the next annual planning period. Once planning is done and some activities are missed out or some gaps are identified later, districts are forced to wait for the next planning period or look for resources from partners to attend to that gap. TA programs should account for this by allotting a proportion of the budget that can be used for provision of supplies and activities that may not be fully funded through the CoC planning.

Appendix I: Data Collection Tools

Study Title: Assessment of the acceptability, level of influence and results of the MCSP/Zambia technical assistance model
Principal Investigator: Dr. Gathari Ndirangu

Appendix 1 – Participant Oral Consent Script

Hello, my name is _____. I work with MCSP, a USAID funded program, designed to provide technical assistance to MoH to implement RMNCAHN services. As part of the program, we are conducting a study to understand the acceptability, level of influence and results of the technical assistance model employed by the program.

What you should know:

- You are being asked to participate in a study
- This consent form explains the study and your part in it
- You are a volunteer. You can choose not to take part, and if you participate, you may quit at any time. There will be no penalty if you decide to quit
- During the study, we will tell you if we learn any new information that might affect whether you wish to continue to be in the study

Purpose of the Study
You may be aware that the Ministry of Health has been receiving government-to-government (G2G) funds from USAID and SIDA to improve RMNCAHN services and that MCSP has been tasked to provide technical support to this G2G initiative. We are conducting a study because we want to understand how well this TA model is working in your location.
We would like to ask you some questions and talk to you about the support you have received from the project. Specifically, we would like to gain a deeper understanding as to what has worked well and other factors affecting the achievement of the projects outcomes.

Why you are being asked to participate
We are asking you to participate in this study because you are a key stakeholder involved in the planning, implementation, monitoring or management of RMNCAHN programs and/or services in your organization.

Procedures
If you say yes, we will ask you some questions. We expect that this will take a total of 60 minutes. You do not have to answer all the questions, and you may stop at any time. Your participation in this study is voluntary. You can withdraw from the study at any time without any consequences.
Risks/discomforts
There is minimal risk that you will feel discomfort about answering questions or inconvenienced as this study relates to your everyday work. We will not collect your name and NRC. Study staff will take every precaution to minimize these risks and keep your information confidential.

Benefits
Although there may be no direct benefit to participating in this study, the information you provide will help program managers, policy makers and donors to determine how to improve RMNCAHN programs and services in your community.

Protecting data confidentiality

Your identity will remain confidential. The project records/forms will be stored under lock and key. Only project staff will have access to these forms. In addition, staff members from organizations funding this project may also review the forms.

Who do I call if I have questions or problems?
Call Victor Kabwe at +260-211-256-255/6/7, who is a co- investigator in Lusaka, Zambia.

If you ever have questions about your rights as a participant, you may contact:

ERES CONVERGE
33 Joseph Mwila Road
Rhodes Park Lusaka
Tel: +260-955-155-633; +260-955-155-634
Email: eresconverge@yahoo.co.uk

May I have your consent to continue?

Yes: Sign and date below

_____ _____ _______________
Signature of Interviewer

No: Thank the respondent for their time

Study Title: Assessment of the acceptability, level of influence and results of the MCSP/Zambia technical assistance model
Sponsor: USAID
Principal Investigator: Dr. Gathari Ndirangu

Appendix 2.1 Key Informant Interview- District/Provincial Officials

Province	District	Date (dd/mm/yy)	Interview number

To be completed by the interviewer

1. Introduction

This interview aims to gain a deeper understanding of the MCSP TA approach, how well it is working, associated factors, challenges, best practices and and how to improve its effectiveness.

READ THE INFORMED CONSENT FORM TO THE RESPONDENT(S) AND PROCEED WITH THE INTERVIEW IF SIGNED.

1.1.1 What is your current position? (WRITE THE RESPONSE BELOW)

1.1.2 Are you a representative of .....: (READ THE RESPONSES BELOW AND CHECK ALL THAT APPLY)

- ☐ 1. MoH- National
- ☐ 2. MoH- Province
- ☐ 3. MoH- District
- ☐ 4. Health Facility
- ☐ 5. CoC - National
- ☐ 6. CoC - Province
- ☐ 7. Implementing Partner- National
- ☐ 8. Implementing Partner- Province
- ☐ 9. MCSP- National
- ☐ 10. MCSP- Provincial
- ☐ 1.1.3 11. Other (SPECIFY): 1.1.4

1.1.5 How long have you worked in this role? (WRITE THE RESPONSE BELOW)

2. Awareness

1.1.6
1.1.7 Have you heard of MCSP? (CHECK ONE ANSWER)

- ☐ 1. Yes
- ☐ 2. No
- ☐ 3. I don't know

2.1.1 Can you describe the program?

1.1.8

1.1.9 Is there any relationship between CoC and MCSP? (CHECK ONE ANSWER)

1. Yes
2. No
3. I don't know

2.2.1 Describe the relationship?

1.1.10

3. Support

1.1.11

1.1.12 Has MCSP provided technical support in your location in the last 6 months? (CHECK ONE ANSWER)

1. Yes
2. No
3. I don't know

3.1.1 Describe the support received? Probe for support related to planning, implementation and monitoring

1.1.13

1.1.14 Which technical assistance strategies were deployed? (CHECK ALL THAT APPLY)

1. Mentorship
2. Service Quality Assessments
3. Trainings
4. Community Engagement Systems
5. Performance Assessment
6. Facility Support Visit
7. PNMDSR/PIMs/DIMs/Data Review Support
8. Data use for decision making / HMIS
9. CoC Planning Support

1.1.1 10. Other (SPECIFY):

1.1.16 Were there challenges experienced in receiving technical support from MCSP in the last 6 months? (CHECK ONE ANSWER)

1. Yes
2. No
3. I don't know

3.3.1 Describe the challenges experienced?

1.1.17 Is the fact that MCSP is not directly funding activities but supporting the implementation of CoC/G2G funds a challenge? (CHECK ONE ANSWER)

1. Yes
2. No
3. I don't know

3.4.1 Explain?

1.1.18 Where there any TA needs that should have been addressed but weren't? (CHECK ONE ANSWER)

1. Yes
2. No
3. I don't know

3.5.1 Which needs were not addressed?

4. Results

1.1.19

1.1.20 Which technical assistance strategies have been most effective? (CHECK ALL THAT APPLY)

1. Mentorship
2. Service Quality Assessments
3. Trainings
4. Community Engagement Systems
5. Performance Assessment
6. Facility Support Visit
7. PNMDSR/PIMs/DIMs/Data Review Support
8. Data use for decision making / HMIS
9. CoC Planning Support

1.1.2 10. Other (SPECIFY):

1.1.22 4.1.1 Why? Explain your answer.

1.1.23

1.1.24 Has TA improved the skills of HCWs? (CHECK ONE ANSWER)

1. Yes
2. No
3. I don't know

4.2.1 How? Explain your answer.

1.1.25 Has TA has enabled the Province/District/Facility implement high impact RMNCAHN interventions? (CHECK ONE ANSWER)

1. Yes
2. No
3. I don't know

4.3.1 How? Explain your answer.

1.1.26 Has TA has improved community engagement systems? (CHECK ONE ANSWER)

1. Yes
2. No
3. I don't know

4.4.1 How? Explain your answer.

5. Recommendations

1.1.27 How best can TA be provided to MoH at Provincial/ District/ Facility level with this model?

1.1.28
6.1 We have reached the end of our interview. Do you have any additional suggestions?

Thank you!

Study Title: Assessment of the acceptability, level of influence and results of the MCSP/Zambia technical assistance model
Sponsor: USAID
Principal Investigator: Dr. Gathari Ndirangu

Appendix 2.2 Key Informant Interview- Partner Projects (CoC, SBH, SM360+)

National Office	Province	District	Date (dd/mm/yy)	Interview number

To be completed by the interviewer

1. Introduction

This interview aims to gain a deeper understanding of the MCSP TA approach, how well it is working, associated factors, challenges, best practices and and how to improve its effectiveness.

READ THE INFORMED CONSENT FORM TO THE RESPONDENT(S) AND PROCEED WITH THE INTERVIEW IF SIGNED.

1.2 What is your current position? (WRITE THE RESPONSE BELOW)

1.3 Are you a representative of .....: (READ THE RESPONSES BELOW AND CHECK ALL THAT APPLY)

- ☐ 12. MoH- National
- ☐ 13. MoH- Province
- ☐ 14. MoH- District
- ☐ 15. Health Facility
- ☐ 16. CoC - National
- ☐ 17. CoC - Province
- ☐ 18. Implementing Partner- National
- ☐ 19. Implementing Partner- Province
- ☐ 20. MCSP- National
- ☐ 21. MCSP- Provincial
- ☐ 22. Other (SPECIFY):

1.3.3

1.4 How long have you worked in this role? (WRITE THE RESPONSE BELOW)

2. Awareness

1.4.1

1.5 Have you heard of MCSP? (CHECK ONE ANSWER)

- ☐ 4. Yes
- ☐ 5. No

6. I don't know

2.1.1 Can you describe the program?

1.5.1

1.6 Is there any relationship between your project and MCSP? (CHECK ONE ANSWER)

4. Yes
5. No
6. I don't know

2.2.1 Describe the relationship?

1.6.1

3. Partnership

1.6.2

1.7 Describe the day-to-day working relationship between MCSP and personnel/counterparts on your project?

1.7.1

1.8 Are the projects complimentary? (CHECK ONE ANSWER)

4. Yes
5. No
6. I don't know

3.2.1 Explain?

1.9 Are there overlaps in roles played by MCSP and your project? (CHECK ONE ANSWER)

4. Yes
5. No – Skip to 3.5
6. I don't know

3.3.1 Explain?

1.10 How are these overlaps being addressed?

1.11 What challenges have been experienced working together?

1.12 What successes have been achieved from the partnership/synergy with respect to delivering project activities?

1.13 How can the partnership be made more effective?

4. Recommendations

1.14 How best can TA be provided to MoH at Provincial/ District/ Facility level with this model?

1.14.1

5.1 We have reached the end of our interview. Do you have any additional suggestions?

Thank you!

Study Title: Assessment of the acceptability, level of influence and results of the MCSP/Zambia technical assistance model
Sponsor: USAID
Principal Investigator: Dr. Gathari Ndirangu

Appendix 2.3 Key Informant Interview- MCSP Staff

National Office	Province	District	Date (dd/mm/yy)	Interview number

To be completed by the interviewer

1. Introduction

This interview aims to gain a deeper understanding of the MCSP TA approach, how well it is working, associated factors, challenges, best practices and and how to improve its effectiveness.

READ THE INFORMED CONSENT FORM TO THE RESPONDENT(S) AND PROCEED WITH THE INTERVIEW IF SIGNED.

1.15 What is your current position? (WRITE THE RESPONSE BELOW)

1.16 Are you a representative of .....: (READ THE RESPONSES BELOW AND CHECK ALL THAT APPLY)

- [ ] 23. MoH- National
- [ ] 24. MoH- Province
- [ ] 25. MoH- District
- [ ] 26. Health Facility
- [ ] 27. CoC - National
- [ ] 28. CoC - Province
- [ ] 29. Implementing Partner- National
- [ ] 30. Implementing Partner- Province
- [ ] 31. MCSP- National
- [ ] 32. MCSP- Provincial
- [ ] 33. Other (SPECIFY):

1.17 How long have you worked in this role? (WRITE THE RESPONSE BELOW)

2. Technical Assistance Strategies

1.17.1

1.18 Which technical assistance strategies do you feel have been most effective? (CHECK ALL THAT APPLY)

- [ ] 11. Mentorship

12. Service Quality Assessments
13. Trainings
14. Community Engagement Systems
15. Performance Assessment
16. Facility Support Visit
17. PNMDSR/PIMs/DIMs/Data Review Support
18. Data use for decision making / HMIS
19. CoC Planning Support
20. Other (SPECIFY):

1.18.2 2.1.1 Why? Explain your answer.

1.18.3

1.19 What are the most important successes achieved through the utilization of this model? Probe for successes related to planning, implementation and monitoring!

1.19.1

1.20 What lessons were learned in implementing?

1.21 What are some critical course corrections made during implementation that are instrumental to the success of this model?

1.22 What other challenges were faced in implementing that are unique to this TA model?

1.23 Are there any suggestions on how to resolve these challenges and improve the model?

3. Recommendations

1.24 How best can TA be provided to MoH at Provincial/ District/ Facility level with this model?

1.24.1

4.1 We have reached the end of our interview. Do you have any additional suggestions?

Thank you!

Appendix II: Interview Summaries

Appendix 1: Summary of National Qualitative Findings

Table 2: Summary of Findings

Theme	Main Findings
Awareness	Summary Findings: It's a consortium supporting implementation of the RMNCAH CoC in 4 provinces. It's a USAID funded project providing demand drive TA. MCSP was described as a consortium organization supporting the implementation of the RMNCAH CoC in 4 provinces, to provide demand driven technical assistance. *"….MCSP is a consortium which has Jphiego as the lead, jhpiego is responsible for the component of maternal health, JSI is responsible for child health, Save the Children is responsible for community engagement and newborn, PATH is responsible for nutrition. MCSP is a TA partner for a government RMNCAH program COC program and it is being funded by USAID. Other than SBH, MCSP is responsible for mentorship. They have presence in 4 provinces, the provinces been supported by SIDA, Eastern and Southern province and Luapula and Muchinga by USAIDS. The work is around providing demand driven TA and advising on the content of the COC plans…."* *"….It's a maternal and child survival project, learnt about it during last year's planning circle, when they just started. During the inception of the project, I was requested to make a presentation which included areas of maternal health, adolescent health, child health and nutrition. MCSP is supporting these areas, they are in Muchinga, Luapula, Eastern and Southern province….."* *"…..the relationship exists, MCSP has an objective of ending preventable maternal death, which is the ultimate goal of RMNCAH CoC program. The experience MCSP has and the lessons from other countries, the lesson are being shared with the program in Zambia…."* *"….MCSP supports services that target improvement of maternal health, child survival and my roles looks at these areas on a daily basis. There is a relationship between MCSP and RMNCAH. All the work MCSP is working on is a function of reproductive and maternal health and nutrition…."* *"…MCSP is present in 4 provinces, the support they give is guided by the data like scorecard, SQA and depending on the performance of the district MCSP advise on the activities to be included or dropped on CoC plans so that they can improve. MCSP TA depends on the status of the district which is informed by data. MCSP TA is 80% at the district and facility level…."*
MCSP Technical Support	Summary Findings: National level has heard of the support MCSP has provided to provinces, but is not formally informed through reports. No reports are submitted to highlight the support MCSP is providing MCSP has been providing support to the provinces in different ways, but has not been engaging and updating the national level staff. Support has been through the CoC planning and through data review and field visits. *"….Based on the feedback I get from the provinces there is a lot of support that MCSP has given to review the plans, assisting the districts of what activities to include based on the data that has been reviewed….."*

Theme	Main Findings
	"….what is seen as a gap, MCSP has officers who are active in terms of getting to areas of delivery to the districts. However, there is little interaction between MCSP and the national level in terms of giving support in the areas of implementation. It has not been easy for us to know what exactly MCSP is doing. *Having said that, I have been to close out meeting like in Eastern Province, that is where I saw the participation of MCSP. There has been very little interaction, hence it is very difficult for me to say what TA we have received from MCSP….."*
Challenges with TA provided	<u>Summary Findings:</u> The key challenges identified include weak coordination systems, lack of buy in or support from the national level and lack of participation of MCSP in the planning process at national level: *"…., it's not clear if the coordinators are going on well among the two TA partners and the provincial CoC leadership. I think it is not going on well. How it can be addressed, for Luapula it's not a challenge because the leadership understand the role of the TA. We need to ensure provincial leadership buy in and they understand the role of the TA partners…."* *"….Definitely the TA can make a difference, but we need to plan together, conduct the bottle neck analysis and identify what activities to be implemented together again Looking at funds from central government is limited support from partner's supplements government resources. If planning is done together, it will help to highlight areas that central government is able to fund and areas that need support from partners like MSCP….."* *"….the other challenge tis that last year when planning we did not conclude the planning process together with MCSP, and at the end of the planning, we should share the plans so that we know what is in the MCSP plans. This helps to leverage on the resources and understand what is been addressed through our partners in the work plan. MCSP must share its work plan particularly. We need closer collaboration to identify areas that need support. Some things can be resolved at lower level some at higher level. We need to ensure that we are planning together to know what we can be supported and what cannot be supported Sharing the work plans, once we agree what will be supported. It becomes easy to evaluate ourselves at the end of the project also and identify what worked and didn't work….."*
Funding –MCSP	<u>Summary Findings:</u> The funding approach is not a challenge as this is meant to build capacity in the districts also. Districts also received GRZ funding directly from central government, hence this approach is not different; *"….One of the objective of the program is to strengthen the capacity of the districts and this is one way of ensuring capacity is built in the districts to be able to manage the resources. The only challenge is how best it can have done to ensure effective coordination between the national level and the districts so that we are able to achieve the objectives. Sometimes the national level is taking up some activities that do not speak to what is required in the districts…"* *"….In terms of direct funding to districts and MCSP going to provide TA, this is a good model, the only gap is the communication to indicate the gaps identified and the support to be provided. The collaboration between the central level and MCSP. Even from central government, resources go direct to the districts and this has improved service delivery. The gaps is mostly communicating what will be supported by MCSP….."*

Theme	Main Findings
Unmet TA Needs	Summary Findings: The project design is adequate to cover all the TA needs and it will be helpful to ensure full participation of MCSP in the national level planning to ensure all areas are covered: *"…Going by the design of the project, it encompasses everything and it should be able to deliver on all areas….."* *"…Concluding the national level plans together and sharing the plans…."* *"…I don't understand the specific activities MCSP has been implementing or the TA they have given for me to directly relate to the results….."*

Appendix 2: Summary of Provincial Qualitative Findings

2.1 Southern Province

The following summary table has been compiled from the qualitative interviews conducted in Southern province from 16th – 21st July 2018 from 5 districts namely Choma, Kazungula, Livingstone, Monze and Pemba. Interviews were also conducted from 5 facilities in the same districts, with SBH and MCSP staff. Table 2 below highlights the summary of key findings from the interviews;

Table 3: Summary of Southern Province Interviews

Theme	Main Findings
Awareness	Summary Findings: All the provincial and district level informants have heard about MCSP and they described it as a partner that is providing technical assistance in RMNCAH&N. They understand the role of MCSP which is to offer support to the G2G program. Some districts think MCSP only focuses on maternal and child health All district level informants and 60% facility level informants agreed that a relationship exists between MCSP and CoC. Some facility level informants are not clear about the role of MCSP although they have heard about it. 60% of the facility staff have heard about MCSP with the majority describing MCSP as an organization supporting maternal health. All provincial informants have heard about MCSP and described it as an organization introducing high impact interventions and supporting districts and facilities with mentorship. *"……Is a Maternal and child Survival program which is USAID funded, and its main aim Introduce high impact interventions operating in several countries including Zambia providing technical assistance to GRZ RMNCAN&N program…."* District level informants across the different levels indicated that they have heard about MCSP and described it as a program that supports the G2G program under SIDA, supports maternal and child health programs and provided technical assistance to districts and facilities. Most district level informants are clear about our areas of focus;

Theme	Main Findings
	"…. It's a program that supports programs under the SIDA funding supporting G2G program offering technical assistance in the activities we are doing under SIDA…." *"…. Its maternal and child survival program and basically for the RMNCAH&N their two components there are funds that go directly to the districts as implementers and they are funds that go to MCSP for technical support to the program …"* *"….It's still unclear to what extent they need to be part of the RMNCAH&N, we have programs sometime they'll be silent, I would love to see them more often pass through and be part of what we are doing…."* The relationship exists between MCSP and COC according to all the district level informants and it focuses on supporting RMNCA&N activities. Others also indicated that the key difference was more on the funder and that MCSP focused on supporting and monitoring the G2G. Facility level informants were not very sure about the role of MCSP although they have heard about MCSP. They were very general in describing MCSP. Some described MCSP as an organization that is responsible for rendering support to facilities in commodities and funding, other shared that MCSP was helping with maternal issues in facilities; *"…..It's a program that supports maternal issues and child survival issues themselves, the support runs through the health of the women streaming down to the children and also it offers support in training and mentorship programs to the professionals in the Ministry of Health…."* In terms of the relationship between MCSP and CoC, some facilities agreed that a relationship existed that focused on RMNCAH & N activities: *"MCSP they are helping us in these areas of reproductive health, neonatal, maternal child, also nutrition and adolescent. For example MCSP has been here to provide mentorship, on-site mentorship at our facility how we could improve MCH indicators. They also done training of community health workers we call SMAGs in partnership with SM 360 so that they can sensitive women about the importance of coming to the facility, danger signs to the mother and danger signs to the neonatal. They have trained 20 SMAGs, they've also trained four staff in ToT for SMAGs am also one of them. They've also been giving incentives to the community health workers, like bicycles, even bags, rain coats, gumboots, t-shirts, phones for easy communication…."*
MCSP Technical Support	<u>Summary Findings</u>: All district level informants indicated that they have received technical support from MCSP in the last 6 months and it focused on capacity building in SQA, mentorship, adolescent health guidelines and MTEF planning. 90% of the facility level informants reported that they have received TA from MCSP in the last 6 months and the TA focused on planning and supporting the implementation of the CoC activities. District level staff cited mentorship (40%), SQA (40%), CoC Planning (40%) and community engagement (10%) as the technical strategies deployed by MCSP. At facility level 60% cited mentorship as a TA strategy, and others used the SQA, trainings and orientations. District level informants indicated that they had received technical support in the last 6 months mostly through orientation in tools like SQA, Mentorship and guidelines such

Theme	Main Findings
	as adolescent health strategy. Support was also given in MTEF planning and support to the districts and facilities. *"…. Yes, at district level, Introducing SQA tool looking at the dashboard and went to one facility where we tested the tool…"* *"…..Came through once or twice, because we have this indicator antenatal visit before 14 weeks, they came through to find out what interventions we had put in place if they are not working could we consider changing intervention. We needed some clarity as an office, for example we had planned to procure tents as a district we noticed outreach was not being conducted because we don't have structures in the outreach post but we were told that we can't procure it will be done centrally and for me it's something we really needed to conduct outreach activities and we failed to conduct outreach activities because the tents were not forth coming and at some point we were told that MCSP will actually procure for us and we did some re-planning and that did not happen and they came to clarify that actually we are not into procuring of anything so whatever you did you need to re-plan so that you can purchase on your own…"* *"….We are all complimenting the activities of Ministry of health, we start with the planning phase, when we plan, the district will put in their activities after identifying the gaps, after putting up those activities MCSP will look at the work plans and fuse out some of the activities which they feel they can do according to the technical workmanship they have and also the districts where they are not comfortable where they need technical assistance, they would write to the province requesting for technical assistance then the province will communicate to MCSP to go to that area where there is need…"*
Challenges with TA provided	<u>Summary Findings:</u> Provincial level informant indicted the need to harmonize the harmonize MCSP TA to the province. 80% of the district and facility level staff interviewed said there were no challenges in receiving TA from MCSP in the last 6 months. However, some raised the following: Weak linkage or clarity between MCSP and the provincial health office Unfulfilled commitments by MCSP to some districts related to purchase of some equipment. Late engagement of districts by MCSP when visiting districts for TA. Less interaction between MCSP and the districts and facilities. Most district informants expressed concerns on some promises that MCSP made to the districts but were not fulfilled such as procurements of child related pieces of equipment and this affected most districts who had reallocated the resources: *"…. The only challenge we've had is the misunderstanding, at first we did not understand what MCSP was all about because at first we thought this is a partner who want to give support in maternal health we thought they've come with their own budget line, we thought they've come with their own package but later on we were told they will just oversee this program, only offer technical support…."*

Theme	Main Findings
	One district level informant indicated misunderstanding the role of MCSP in the district, as they expected MCSP to fund some activities in the districts with a separate budget from G2G: *"…The only challenge we've had is the misunderstanding, at first we did not understand what MCSP was all about because at first we thought this is a partner who want to give support in maternal health we thought they've come with their own budget line, we thought they've come with their own package but later on we were told they will just oversee this program, only offer technical support ….."* Another challenge at districts level is the late engagement of districts by MCSP when it came to supporting them and some districts didn't know how to access TA from MCSP: *"…..Another challenge is that, for example if they have a program with us they would not give us notice in good time so that we are available they will just tell us that actually we are coming in the afternoon meanwhile we have other programs we need to do and we needed to agree which time is actually good to meet…"* *"…But the only challenge was in terms of communication, because at one point it was noted that they are not coming and then the reasoning was that we are not requesting so I don't think we were aware that we need to request from MCSP for some of the technical support in some of those activities…."* *"…..Another challenge is that, for example if they have a program with us they would not give us notice in good time so that we are available they will just tell us that actually we are coming in the afternoon meanwhile we have other programs we need to do and we needed to agree which time is actually good to meet…"* Others said they have not interacted much with MCSP *"…Its difficult for me to say because the only time have really seen them is during the time they came for that technical support when they were giving us information on how to go about the SQA…."* One facility level informant cited the limited time for the TA provided through training. *"….The only challenge that I found as an individual was the time or duration was short as compared to the amount of topics to be covered, it was a five days training but when I went through the manual it should have been two weeks because a lot of things had to be covered…."*
Funding –MCSP	<u>Summary Findings:</u> 80% of district and facility level informants think it's not a challenge that MCSP is not directly funding activities because MCSP's objective is clear to provide technical support, districts receive funds for activities and MCSP supports and covers its own costs. It's important that the TA is aligned to the district planned activities. It's a challenge for some because it's not clear to what extent MCSP is part of the RMNCAH&N program in the district. Most districts indicated that it was not a challenge that MCSP was not directly funding the activities and emphasized the need to ensure that the TA MCSP was providing is linked to the planned activities by the districts.

Theme	Main Findings
	"…It is perceived by many that it is a problem but I'll tell you one thing it's not a major problem, it's just something we need to sit down and communicate because MCSP has the expertise to offer mentorship and Technical Support we do have funding to organize an activity instance a training, if we sit down and work together that can work perfectly well the most important thing is to sit round the table look at the plans have a schedule that is common and implement as a team, I don't see any challenge because I see the staff from MCSP as added advantage in terms of staffing because when you go to do mentorship as a team you have a bigger team that helps the people at the facility…." *"….Since their objective is clear their role is just to offer technical support, I guess we can't expect much from them but it may be a challenge in that if their programs are not married to our programs then it means that when they come at a time when we've probably done a certain program and they also want to do a different program and they have to go to a facility and offer technical support in ART or anything else it may be a challenge because that person they've take out in the field may expect a lunch allowance since they are not offering any material support then that becomes a challenge…"* *"…Not a challenge per say because when they do come they take care of their own logistics and they even come with the materials but probably the question could be when you want technical support would you call on MCSP or you might seek another body that's in your area that's already functioning that has worked with you before…"* One district indicated that it was challenge because it was not clear to what extent MCSP was part of the RMNCAH&N program: *"…It's still unclear to what extent they need to be part of the RMNCAH&N, we have programs sometime they'll be silent, I would love to see them more often pass through and be part of what we are doing,…"*
Unmet TA Needs	<u>Summary Findings:</u> 60% of the district staff and 40% facility staff interviewed indicated that MCSP did not address some needs that included participating in data review, child health week meetings, trainings etc. TA needs exist in the province that include supporting Child Health activities, adolescent health activities. Some opportunities for TA have been missed by MCSP, because districts don't inform or invite MCSP. TA opportunities exist at facility level in areas such as capacity building in mentorship and supporting SMAGs. District level respondents indicated that some TA needs still exist which according to them include the need for logistical and financial support to undertake activities and timely support from MCSP to support activities: *"….We invited them for the safe motherhood week and when we have programs like child health week I think we extended our invitation to them and they never came…"* *"…We did have a number of meetings under the SIDA funded program like some adolescent trainings, peer assessments trainings, it wasn't really a challenge but I think maybe would have been added advantage if we had included MCSP in those meetings, since they are providing assistance towards the RMNCAH&N activities…."* *"….We would have loved MCSP as well despite offering technical assistance to also have a small resource that could be used by the district in an event there is an urgent need or a bit of contingent which can be used to support the district of to support the district…"*

Theme	Main Findings
	At facility level some indicated the need for MCSP to continuously provide TA to them especially when it comes to activities such as capacity building in mentorship, supporting SMAGs etc. *"……I would have loved to see MCSP in our meetings, SMAGs meetings and have the money allocated to that meetings available and sometimes just once in a while give technical support like Nakatindi Clinic what is needed at your disposal, this month you're supposed to get this money for SMAGs, mentors us in areas our staff are not oriented or maybe the facility staff are not oriented how the RMNCAH&N money is supposed to be used. The district so far has given us the guideline on the budget that around this time you're supposed to request for this money for this activity for RMNCAH&N and they are also in relation to MCSP…."*
Results- Effective Strategies for TA.	<u>Summary Findings:</u> Effective technical strategies at district and facility level include mentorship (40%), trainings (40%), SQA (10%) and technical support. SQA has helped facilities in identifying gaps and mentorship has helped them improve and support others like SMAGs. SQA is effective because its practical for most district staff and it helps identifying gaps In terms of the effective TA strategies used by MCSP, all the districts indicated SQA orientations, mentorship and CoC planning as some of the effective strategies used by MCSP to provide TA. TA given through strategies like capacity building in SQA has helped some districts in identifying gaps and TA in CoC planning has helped some districts re-focus some of the activities and resources to address the gaps identified: *"…All that they've come to do has been of help. For SQA though still ongoing but from the few facilities we've gone to we've been able to identify some of the major gaps that have come in, but with planning we've been able to re-focus some of the plans that were previously made and redirect them to things that would have greater impact. I was also quite impressed with the community engagement package, they helped has come up with a laid down plan of how we should get community engagement at all the various levels starting with the technical committee for the whole district and moving on to our health promotion team at the district and also going further to looking at the facilities and how the facilities are engaging with the communities, the discussion we had was quite holistic we discussed a number of things…."* *"…The SQA is a very effective tool because it helps us to see were our problems are it uses a dashboard system so if you are in green you automatically see that you are doing fine in this area but the moment you see a red it opens up your mind and eyes that this area really need to be looked at as a district so it's a very effective tool in nursing were our problems are and formulating strategies to look at those problems …."* Informants at facility level also shared that also indicated that orientation in SQA was helpful in identifying the gaps; *"…..SQA was covering a lot of areas, with that one we were able to see because in each service we were able to grade ourselves here we are lacking and this one we don't have and if that one is consistently done I think it will make things happens because it will be asking do you do this do you that. It's more of integrated issue based type of approach…."* *"….They awarded our clinic for the services that we are doing and that's a plus for us, and also help in the community for the SMAGS…"*

Theme	Main Findings
Improvement in HCWs Skills due to TA	<u>Summary Findings:</u> 60% of district level respondents indicated that TA has not improved HCWs skills because limited time they have worked with the districts in Southern. 80% of facility level indicated that MCSP TA has improved HCWs skills, because TA provided through trainings, mentorship has improved their skills. Skills improved at district and facility level are mostly non-clinical like planning, data review and use of score cards. Other areas include use of equipment. Assessment of changes in skills has not been done. District level informants had mixed experiences on whether TA had improved HCWs skills, some district informants said TA had not improved skills because of the limited interaction with MCSP *"…..It's difficult for me to agree to that or disagree because they've really only been in the district once and that technical assistance was offered at the district level and so for now I can say have not yet assessed whether the people have actually acquired that skill yet because that tool hasn't been rolled out…"* The other two district informants indicated that TA had helped improve skills in planning, data review and use through use of score card and use of high impact interventions: *"…Yes and no, in that, for you to evaluate an impact you need time, and when you look at the time MCSP started operating full time with the districts we are probably starting from January this so we can not probably attribute any high impact to what has happened but In terms of indicators we are seeing a bit of improvements but that might be multi-faceted and we cannot attribute it to just one approach…."* On the other hand, facility level informants from all the four facilities indicated that TA has helped in improving skills in areas such SQA and onsite mentorship. Others cited improvement in use of equipment "…. *For instance, for nutrition, I think there was a time we were not doing the height for weight, stunting and wasting for children, so from the time they came they were able to take us through and with help also from the district so it was some double effort from MCSP and the district…."* *"…..It has helped us in that, in our course we had a part were we did some clinical workouts, so even in the manual it is there for instance we never used to do certain things for example antenatal booking the first a mother comes for antenatal we would of course get the biographical data but when it comes to calculating of the EDD sometimes we would just guess and we don't use the fetal scope to check viability of the baby, certain things in the physical examination we would not do them, we would just look at a woman clinically without telling them to undress to check, now with the data collection (mentorship tool) tool it has given us guidelines…."* *"…. We had many gaps for us we thought mentorship was about talking about things and not give chance somebody to give a feedback. We really gained more in the communication because we discovered that when feedback is given we're going to know …has this person learned the skill or not and the other thing that we learnt was that the mentor had something to do not just using the finger pointing do this do that the mentor has to show the skills for her/he to be called a mentor has to be highly skilled and efficient being competent in doing certain procedures…."* *"…. It's an ongoing thing, like I remember in IMCI that every child should be managed according to IMCI. When they came in terms of human resource we have two clinical officers,*

Theme	Main Findings
	seven nurses, one environmental and nine lab and two people were brought in the meeting I think from there we were able to disseminate what we discussed, I think from what we discussed people have started trying to do things according to policy guidelines and all those requirements I think somehow its improving…."
MCSP TA Improving Implementation of HII	<u>Summary Findings:</u> 60% of district level staff indicated that TA by MCSP has enabled district implement high impact RMNCAH &N interventions through use of scorecard to identify gaps and identifying activities. All the facilities level staff indicated that TA by MCSP has helped the facilities implement high impact RMNCAH&N interventions through the onsite support given, mentorship and orientation in certain guidelines. District level informants agreed that TA has helped the districts in planning for high impact interventions during planning and data reviews. Use of SQA and score cards helps in identifying gaps and use of high impact interventions: *"….For example, one of the RMNCAH&N areas is the issue of maternal mortality, when we were assessing our data for the previous quarter, quarter four of 2017, there were a number of high incidences of maternal mortality, so after some mentorship and meetings, we basically initiated some interventions to find out why, so it was found out that a lot of these cases were being referred maybe late to the hospital, and the mentorship provided guidelines how they should do the referrals and the timeframe they are supposed to do it and what to look for so those have been the high impact interventions that have been put in place….."* *"….The district is vast and the distance between health facilities being the biggest challenge so to overcome that the best way was to get the people involved and this actually came towards communicate engagement. With our current plan, we have a lot of refocus towards neighborhood health committees and refocusing back to the community health workers, community engagement, sensitization and a lot of community activities we added trying to get the community involved considering the fact that it's easier to get the community involved even if the distances are far apart….."* All facility level informants agreed that TA has helped in use of HII and has helped in improving service delivery. *"….We've reduced on the maternal and neonatal deaths, because of the mentorship we are able to provide quality services to the mothers and refer in time. We are able to see the mother in ANC, encourage them to come early for ANC. We were reminded how to resuscitate the babies so we don't have many still births…."* *"….It has helped us implement activities to bring change because if you look back into our data, from the time we started and where we are its different in terms of the indicators, for example under immunization we are able to achieve 100 percent, under antenatal first booking we are able to achieve 80 and above. After the training of the CHW, CHW have continued to sensitive the community at large, they go door to door, in their respective communities and zones, to sensitive the community about the services we are providing at the facility, for example if a child is due for immunization they'll always remind them and communicate with them that you have to go to the clinic, even antenatal they are able to remind them, so that they can receive those services, by so doing you'll find that the numbers and figures we're supposed to achieve….."*

Theme	Main Findings
MCSP TA improving Community Engagement Systems	Summary Findings: 60% of districts level staff believe MCSP is helping improve community engagement systems mainly through trainings. 80% of the facility level staff indicated that MCSP TA has improved community engagement mainly through stakeholder mapping and trainings. District level informants indicated that MCSP TA was helping improve community engagement systems through trainings in community engagement approaches *"…….We are working as a team, and we a have trained a number of SMAGS, and we had a number of community meetings and recently we were actually having an orientation as a district on community engagement by MCSP, the package that we can use to create more demand and that was also done again at the provincial meeting in Livingstone a talk was given on community engagement, and I feel once we get hold of our communities then we would have scored 80% of our successes because our target is the community …."* Facility level informants agreed that MCSP TA has improved community engagement systems mainly through trainings activities and stakeholder analysis: *"…..We have analysis of our stakeholders including the church, traditional leaders any other school, for instance during the child health week we engaged the church, schools, traditional leaders, even the results from the CHW have improved…."* *"….The way we are engaging the community under RMNCAH&N, there is another NGO helping us SBH, and Contact Tracing Youth Association, to do trainings on community quality improvement in the community, to train CHWs in quality improvements in leadership and also in community planning, SBH also came to help us to train the community in community management and leadership and also in quality improvement in the community, and planning, by so doing we were able to engage and manage the community in an effective way…."*
Recommendations	Summary Findings: The district informants proposed the following recommendations to improve: MCSP needs to plan together with the districts MCSP should plan and schedule field visits together to help ensure sustainability and ownership MCSP should support districts in conducting trainings as trainers Orientation of districts in the role of MCSP should be continuous. *"…We just need to twist it slightly, just minor improvement, because I always don't want to think of outside to do what you are supposed to do because 90% of the efforts and energies are within you, so the most important thing if we are to push this forward is to continue sitting and planning together, sharing our plans we have the resources to conduct these many TAs during these periods, we need to synchronize and plan together, what we don't want is a situation where MCSP goes on its own in our facilities that we discourage because ownership and sustainability must be with the Ministry of Health so if we fragment ourselves we may fail to sustain or get to understand what our colleagues are doing, and the advantage to that is that, MCSP are like CIA for lack of a better term who are supposed to operate independently and offer independent technical advice because I might be biased because am the owner of the program and I may want to preserve my position, but an independent observer may give objective advise to you that in this area you need to improve in these ways and so on…"* *"…..When we are having a training for example if they are able to provide trainers I think that will be of help if they can't provide trainers if they are able to provide help with regards to financial material help whereby we can identify the trainers and they help as pay the*

Theme	Main Findings
	trainers because usually trainings like EmONC takes about 14 to 16 days and we have to pay trainers for every day that they are available, we have to pay for material, we have to pay for stationery so it's a very expensive training, if they can help us identify trainers and pay trainers then that would be of help. One of the things is that, as they are planning to offer any technical support the first thing they have to do is to come to the district and marry into our plans for example and say what is it you are doing as a district in this quarter or this year and from there we work together as a team like in this program this the level of support we can offer and so as we do our programs we are doing in partnership with them…." *"…..Probably just more detail on how, especially for Southern Province we still have number of DHDs who are relatively new so they might need more details about how MCSP goes about their business…."* Facility level informants had the following recommendations: Continue with onsite TA Frequent and consistency in TA provision Cover more staff during onsite TA *"…. They should continue with their services to us in mentorship and also supporting us as a clinic in terms of equipment…"* *"….They should conduct Supervisory visits even randomly they don't let us know that they are coming of course letting us know would be better but if they do them over a period of time they just come randomly to see what we are doing for instance maternal death review death if we don't have any we pick a few from the hospital and if we found out that was our mother/client we say what we did before we referred because what matters in maternal cases is the initial care that was given and also the continuation in mentorship staff trainings like in this clinic we are just two of us who are trained mentors. Whenever they come to do supervisory visits if they find out that its beyond us or maybe it's the Ministry they should come in for instance we don't have machinery equipment like the resuscitating machine they should come in and get them for us when we are to resuscitate a new born who has asphyxia and a few other gadgets for maternal…."*

2.2 Eastern Province

The following summary table has been compiled from the qualitative research conducted in Eastern province between 23-27th July 2018. The research team interviewed 6 district health staff from 5 districts, 5 facility level staff from 5 facilities, 1 provincial health staff and 2 partners at the province i.e. SBH and SM360+. Hence the key findings are from interviews at provincial, district, as well as the sampled health facilities

Table 4: Summary of Eastern Province Interviews

Theme	Main Findings
Awareness	Summary Findings: Provincial level informant indicated that MCSP was in the province to provide technical assistance to the districts in RMNCAH&N. 100% of the district health informants interviewed have heard about MCSP and understand the linkage between MCSP and CoC. MCSP is providing demand driven TA to help implement the RMNCAH&N CoC in the districts. 100% of the facility informants interviewed have heard about MCSP, but do not understand the linkage between MCSP and CoC. Some describe MCSP as a funder like SIDA.

Theme	Main Findings
	Provincial level informant indicated that MCSP was in the province to provide technical assistance: *"…..MCSP will be there to provide Technical assistance to the districts and provincial health office in an effort to strengthen the RMNCAH&N program….."* All district informants indicated that they have heard about MCSP and described it as an organization providing demand driven TA, strengthening systems and a partner providing TA to RMNCAH&N program. One informant highlighted that "…. *MCSP provides technical assistance to districts receiving CoC funds and they provide support to CoC funded activities under the RMNCAHN program…."* *"…MCSP focuses on technical support to the districts in mentorship to ensure that services are provided to standards set by the ministry of health…"* All facility level informants mentioned that they have heard about MCSP and described it as an NGO, an organization supporting maternal and child health programs. *"…. MCSP are helping facilities with maternal and child health and bringing services close to the community…"* *"…It is an NGO that is providing technical assistance where we can improve our service delivery and part of our equipment that we use to improve our performances…"* However, some facility informants seem not to understand the linkage between MCSP and CoC. One informant described MCSP as replacing SIDA and another informant described CoC as supporting MCSP. *"…It was previously called SIDA but it's now MCSP. SIDA used to fund us in several programs such as trainings and capacity building to improve our skills while MCSP we are still being given technical support and mentorship so we continue achieving what we learn so where we are not doing well we can improve…."* *"….CoC is supporting MCSP…"* One informant however, indicated that "….*all the support in form of RMNCAH&N is coming from the same USAID. The two they are a family because they are targeting the same, mother and the newborn…"*
MCSP Technical Support	<u>Summary Findings:</u> 100% of district level informants indicated that they have received TA in the last 6 months that focused on the following; SQA to facilities and use of dashboards Guidance on EPI, Infection, prevention Trainings Planning for DIM *(Data analysis and review of indicators)* Community engagement- introduction of community tool Use of scorecard Use of protocoled and implementation of ADSRH services Mentorship The TA strategies used at district level included: SQA Trainings Mentorship, PIM/DIM/Data Review

Theme	Main Findings
	Planning, data use 100% of the facility informants interviewed indicated receiving TA from MCSP that focused on the following: Mentorship Use of facility dashboards Review of facility level data on asphyxia Effective TA strategies deployed at facility level included: Mentorship Data use for decision making Facility support visit District level informants indicated receiving TA from MCSP in the last 6 months that focused on capacity in SQA, community engagement tools, trainings, planning and mentorship activities: *"…..They have provided support in planning DIM and data review meeting. With regards to planning they helped us how to analyse indicators and identify gaps by using the scorecards. Also introduced us to the community tool where the community can be engaged in terms of planning…"* *"…Supported the district during child health week, provided us with protocols and how to implement ADSRH services for adolescents. They gave guidance on what to include in the 2019 Plans…."* *"…. Mentorship to DHO, Nyimba district hospital and facilities in form of ways we can improve service delivery and how these services would have an impact. In terms of planning they guided us on how to plan and how best the funds we are receiving can be put to good use and how we can attain our goal…."* The strategies used at district level according to the district informants include the use of SQA, mentorship, training and data use while at facility level mentorship and data use was the most used strategy. In terms of the TA received facility level informants shared that MCSP provided support in reviewing data on asphyxia, mentorship and use of guidelines: *"…MCSP came to look at the asphyxiated high numbers that the district is contributing and thereafter provided support to the facility staff. MCSP provided support which resulted into reduced asphyxiated babies. MCSP also left the forms which we are using in labor ward to help the staff in labor ward follow closely. The other team that came also provided with some equipment like penguin suckers, cord clumps and the other instruments…."* *"…Support and mentorship in Essential newborn care, EmONC, family planning and antenatal…."* *"…. Supported us on improving the labour ward, MCH and guidelines…"*
Challenges with TA provided	<u>Summary Findings:</u> 80% of district level staff did not experience any challenge in receiving TA from MCSP. TA sometimes depends on the availability of MCSP staff. All the facility level informants indicated that that there was no challenge with receiving TA from MCSP. However, one facility indicated that MCSP did not announce or make an appointment before visiting the facility.

Theme	Main Findings
	Most of the district level informants interviewed said they did not experience any challenges in receiving TA from MCSP in the last 6 months. *"….Major challenge is that its demand driven in that it's dependent on us calling them to come. So they may be engaged elsewhere and that has posed a challenge…."* Only one facility level informant indicated that the only challenge was that MCSP did not make appointment: "*…The only challenge is that MCSP team come unannounced"*
Funding Approach –MCSP	<u>Summary Findings:</u> 60% of the district level informants interviewed indicated that it was a challenge that MCSP was not directly funding activities because of the following: Resources are need to support certain activities at facility. To influence performance and motivate staff, they need resources 60% of facility level informants also indicated that it was a challenge that MCSP was not funding activities because: Facility level staff are used to getting practical (financial/material) support from partners. They do not have funds to undertake certain activities. However, its not a challenge for 40% because according to them the support still reaches beneficiaries. District level informants indicated that at district level it was not a challenge that MCSP was not providing resources, however for support to be effective at facility level, MCSP needs fund some activities; *"….They do not funds on their own to make a program that we can incorporate in our plan. They depend on funds that we already have as a district and that poses a challenge in their logistical management. It would be better for them to have a bit of funds to support certain programs…."* *"…..Activities normally require support in terms of monetary form or assistance in vehicles to carry out activities. Technical assistance can be good if it's just at district level but at facility level there need for resources if there are no adequate funds. The funds have a work plan but if funds are late then activities cannot be implemented. If they had funds they would meet the current need at that point in time rather than waiting for funds….."* Some facility level informants think it's a challenge that MCSP to does not directly fund activities because interventions (training) require resources and in some cases they will not influence and motivate staff *"…Most other NGOs that are available provide support by funds while mostly MCSP is technical assistance minus funds and sometime facilities cannot do certain things due to funds. If they can come to assist even with things like transport. Another challenge is that programs as we await funds…"* *"…. Funds can be used to motivate and influence performance of staff…"*
Unmet TA Needs	<u>Summary:</u> 80% of district informants indicated that all the gaps were addressed MCSP provided TA to facilities and districts Some districts do not request for TA from MCSP 60% of facility informants think it's a challenge that MCSP is not directly funding activities. MCSP needs resources to address some gaps and to motivate the performance of facility level staff.

Theme	Main Findings
	All the district level informants indicated that there were no TA needs that were not addressed by MCSP TA from the TA they have provided. However, one informant indicated that in most cases districts did not request for TA from MCSP *"…. the situation has been that sometimes the districts don't ask for support from MCSP…."* Most facility informants also indicated that there were no TA needs that MCSP did not address during their TA visits, however, one informant indicated that some needs required financial resources to be addressed *"…..There are activities that we might not be doing due to lack of funds. For example, we do not have EPI manuals but MCSP shared soft copies with us but now we need to print so we have hard copy one. Also we have been lacking Micro cuvettes…."* *"…..Most other NGOs that are available provide support by funds while mostly MCSP is technical assistance minus funds and sometime facilities cannot do certain things due to funds. If they can come to assist even with things like transport.* *Another challenge is that programs as we await funds…"* *"…..Funds can be used to motivate and influence performance of staff…."*
Results- Effective Strategies for TA.	<u>Summary Findings:</u> Most effective TA strategies cited at district level include: SQA (20%) Community engagement (20%) Mentorship (40%) Data use for decision making (40%) Most effective TA at facility level include: Mentorship (60%) Training (40%) Data use for decision making/HMIS (40%) Community engagement (20%) Most district level informants cited SQA, community engagement, mentorship, score card, data use as some of the most effective strategies used by MCSP to provide TA. The strategies have been effective as they have helped the district identify the gaps, assess performance and address the gaps in a systematic way. Strategies such as mentorship help in demonstrating some skills: *"….SQA has helped the district to identify some gaps where we need to improve with planning, and assess our performance as a district. Community engagement is another strategy with is helping to reach our communities in a systematic manner so that the health care services reach the intended and correct population…"* *"…. The scorecard is the most effective in that if indicators are being scored on a regularly basis and we are able to see the scores. We analyze why indicators are performing that way and we can even go on the ground and find out exactly what is happening and put interventions in place..."* *"…Mentorship works well because you are mentoring people on what's already on the ground…."* *"…You work with the service provider and demonstrate steps and procedure…"* Facility level informants also cited mentorship and community engagement as an effective strategy and it has helped them engage the community and facility in strengthening skills in areas such use of partographs, dashboards:

Theme	Main Findings
	"…If people are trained in certain areas that would be of great assistance. Community engagement is important because we are serving the community…." *"…. They trained us in Essential newborn care and we have shared with other centre staff. Also in mentorship they helped us on how to monitor labour and how to use a partograph…"* *"….We didn't have knowledge about the dashboards with the coming of MCSP they taught us how to create dashboards and making follow ups in the facilities through the use of dashboards…"*
Improvement in HCWs Skills due to TA	<u>Summary Findings:</u> All district level informants indicated that MCSP TA had improved their skills in areas such as SQA, mentorship, planning and use of data for decision making. All facility level informants indicated that HCWs skills have improved in different area such calculations of immunization drop out, planning for service delivery and use of partographs. District level informants indicated that there has been an improvement in skills among DHO staff in SQA, mentorship, use of data for decision making and in planning: *"……MCSP has helped the DHO to do SQA and mentorship and this has improved the skills of the staff. For example during the planning process, we are able to know where we are not doing very fine and we concentrate our efforts and resources there….."* *"….Through use of performance management and planning and use of tools and data for decision making. With TA from MCSP program officers now know what their program is looking at and how to analyse data and how to put in terms of planning…"* *"…. Capacity has been built in the DHO staff to provide mentorship to health centre and mentorship is conducted in a systematic way that is helping staff. There is an improvement in indicators indicating capacity has been built in the staff through mentorship…."* *"…In terms of mentorship the more you do the more it really produces results as it acts as a reminder if certain things have been neglected…"* Facility level informants shared that the skills have improved ranging from planning for service delivery, undertaking certain functions such calculation for immunization drop out, resuscitation: *"…..areas ranging from how to use partographs, newborns and the like. Facility staff are able to know the key areas during planning and service delivery. Districts have also made steady progress in many areas in terms of service delivery and if MCSP and SBH can stay longer, the impact will be felt much.* *"….They have helped us in many ways, we are currently even conducting a study to assess the neonatal deaths which will help to sharpen the skills…"* *"…..On newborn resuscitation, sometimes staff would forget certain steps but through the mentorship the steps were retaught and steps are being followed…"*

Theme	Main Findings
	"…..We have known where we are not doing fine as a facility. For instance, child health we were having a challenge in reaching our target but after they mentored us on how to come up with the coverage and how to calculate the dropout rate and that has assisted us in improving our indicators…"
MCSP TA Improving Implementation of HII	<u>Summary Findings:</u> 90% of district level informants indicated that MCSP TA has enabled districts plan for RMNCAH HII, however, delayed funding affected implementation of some activities. 80% of the facility informants indicated that MCSP TA has enabled them implement RMNCAH&N HII in addressing maternal deaths, nutrition, child health All the district level informants shared that TA by MCSP has helped the district's plan for RMNCAH&N high impact interventions in addressing the gaps. However, late funding has been a challenges to implement the interventions: *"….We have managed to include some high impact interventions, however we are a bit behind because some program officers don't like delegating to others and MCSP is here to remind us that we are behind….."* *"…..We have improved in terms of how we are coordinating and implementing the activities and how we are reviewing the plans in terms of RMNCAH&N program…"* *"….Technical assistance acts as a reminder. The more we receive technical assistance it helps us see where gaps might be and improve indicators…."* *"…..This was not due to the technical assistance but delayed funding which affects implementation of activities…"* Most of the facility level informants indicated that the TA by MCSP has helped them implement RMNCAH &N high impact interventions to address gaps such as maternal deaths, malnutrition *"….In terms of maternal health we are working on the reduction of maternal deaths and we are knowledgeable and know when to refer early the women if there is a complication. As well as under nutrition, children with severe malnutrition we are able to manage throughout patient therapeutic program. If we cannot manage we refer them to the hospital…."* *"…Some of the activities and discussions with MCSP have helped us even of management of certain things in the hospital…"*
MCSP TA improving Community Engagement Systems	<u>Summary Findings</u>: 60% of district level informants believe MCSP TA has helped in improving community engagement systems through capacity building in use of community tools and community engagement strategies. The others shared that community engagement was still not active in the district. All facility level informants do not believe that MCSP TA has helped improve community engagement systems because they have not provided TA at facility level in this area. Most district level informants indicated that MCSP TA has helped improve community engagement systems by building DHO capacity in the use of the community tool, community engagement strategies

Theme	Main Findings
	"……Although we still have a long way to do because MCSP will just provide the TA and it's the districts that need to provide support to the community. Example of what was happening in Petauke. MCSP has done their part and what is remaining is the district to do their part since funds are with us….." *"…..They have assisted in developing systems towards community engagement which has helped in creating demand at facility level…"* *"…..Because we had never seen or used the community tool. It has seen an improvement but still needs a bit more funding…"* All facility level informants indicated that MCSP TA has not helped in improving community engagement systems: *"…..Regarding community engagement, we talk of MCSP engaging the community in activities that are normally carried out at the community. They haven't involved the community at large…."* *"….Not to my knowledge…"* "…*Community engagement is not very active in the district…."*
Recommendations	<u>Summary Findings:</u> Development of joint District plans Sharing of plans between MCSP and DHO Development of a schedule of activities indicating which ones require TA from MCSP Agree on schedule on time with the relevant staff and facilities District level informants recommended that MCSP and DHO needed to develop joint plans, share the plans, agree on activities that require TA and ensure that there is timely communication: *"……Joint plans where we need to share plans and know when which activity is taking place at what time. MCSP to have a staff based at DHOs for easy communication and support MCSP to have some leeway in their plan so that they should be able to do something on their own. …"* *"….MCSP to have our schedules of activities that will require technical assistant so they would know where to go at what point because we want them at these activities they need more human resource to cover all districts also increase their funding so they do not depend on the district sharing of stories from other districts…"* *"…..Technical assistance should be frequent and regular and have an officer at the district so as to work closely together…"* *"…Technical assistance is best offered by providing communication in good time by when activities are being done and how many times.* *There is also need for feedback and sharing of reports with DHO as it helps us look at some areas that might have noted by the team.* *Sharing of stories from other districts and what TA has brought out in other districts that will help us how best we can improve in areas we are having challenges where our colleagues are doing well…"* *"…..If MCSP may have some funds to implement some activities so as not to depend on the district in instances where we do not have funds to implement activities…"*

Theme	Main Findings
	Facility level informants also recommended that MCSP needed to provide continuous TA to facilities and needed resources to support certain activities. Facility informants appreciated the TA by MCSP specifically the debriefs conducted after the TA.: *"…..The technical assistance is ok but maybe if there can be funds allocated it would improve the situation/scenario…"* *"….They should visit facility regularly even on quarterly basis so we are updated all the time. Most gaps were in skills of health care worker thus more stuff need to be trained. If they can give us a bit of funds just to use as a facility in terms of supervising the SMAGS…"* *"….The current is the best. There is communication and we have debriefs with the team and we work with them. If there are any follow-ups they are made in no time…"* *"….Visiting the facilities sot ensure the right things are being done and onsite orientations….."*

2.3 Luapula Province

The following summary table has been compiled from the qualitative research conducted in Luapula province over the period 16th – 21st July 2018. The research team interviewed a sample of 12 health staff from the Province (1), district (6) and facilities (5). The table below highlights the key findings:

Table 5: Summary of Luapula Province Interviews

Theme	Main Findings
Awareness	<u>Summary Findings:</u> All district and facility informants have heard about MCSP and described MCSP as an organization providing technical assistance to district in maternal and child health. The understanding of most district and facility staff is that MCSP just focuses on maternal and child health. All district level informants and 80% of facility level informants agree that a relationship exists between MCSP and CoC, which focuses on RMNCAH&N indicators. Lack of clarity about the CoC and MCSP still exist among among some districts and facility level staff as one facility informant indicated that they did not know about the CoC and described it as an organization. Most district level informants described MCSP as an organization providing technical assistance in maternal and child health activities in districts: *"……It's an organization whose key role is giving technical support in RMNCAHN programs in line with G2G activities planned…"* *"….It is a program that is undertaking maternal and child health activities supporting some districts in the province, for example Samfya. A team supporting Technically on G2G funding…"* *"….It is a program supporting all districts in Luapula province. It is focusing on maternal and child health services in form of technical support, capacity building, systems strengthening…"*

Theme	Main Findings
	In terms of the relationship between MCSP and CoC, all the district informants indicated that a relationship exists as MCSP provides TA to RMNCAH&N programs working with MoH: *"…MCSP has been working with the MOH on the SIDA funds to provide Technical Assistance/Support…."* *"….When districts are implementing RMNCAHN activities, MCSP gives guidance & support…."* *"…Both programs focus on the mother and child including nutrition. The teaching they give MOH is similar…"* *"…. RMNCAH&N and MCSP are similar in that they both focus on the same thematic areas…"* *"…. RMNCAHN & MCSP are both focusing on same indicators and MCSP comes in to offer TA in these indicators…"* Facility level informants equally described MCSP as an organization focusing on maternal and child health *"…...I have not had any direct interaction with MCSP since I came here, but from Nchelenge I heard that they will be linked to G2G programs and maternal programs…."* *"…All I know is it deals with mother and child health…"* *"….MCSP deals with mother and child health services, In child health it encompasses immunizations…"* Facility level informants shared that a relationship exists between CoC and MCSP because they both focus on maternal and child heath: *"…I have not had any direct interaction with MCSP since I came here, but from Nchelenge I heard that they will be linked to G2G programs and maternal programs…"* *"…..MCSP deals with mother and child health services, In child health it encompasses immunizations…"*
MCSP Technical Support	<u>Summary Findings:</u> All the districts level informants indicated that they have received TA from MCSP in last 6 months that focused on SQA, mentorship, HMIS, planning, joint support visits to facilities. District level TA was provided through mentorship, SQA, trainings, facility support visit and data use for decision making. 60% of the facility informants indicated receiving TA from MCSP that focused on capacity building in labour management and community engagement. The TA focused on capacity building in guidelines, labour management and community engagement. All district level informants reported receiving TA from MCSP in orientation in SQA, guidelines, planning and onsite mentorship through facility support visits. The TA was provided through mentorship, SQA, trainings, facility support visits and Data use for decision making:

Theme	Main Findings
	"…MCSP has provided SQA to our facilities, and MCSP was the first one to show us how to use the SQA MCSP also provided guidance in EPI, Infection Prevention, and the set-up of the clinic MCSP has provided technical support during trainings…." *"…. Received technical assistance support in line with maternal and child health services. Also services related to how mothers are being placed before, during and after a baby is born. Monitoring utilization of registers, they have provided scorecards to show performance of facilities in the district. Transport support during Child Health Week round 1 2018…."* *"…..Gave TA on G2G funding, MCSP came to give feedback after last revision of G2G. they guided on activities to put in the action plans…"* *"….We visit facilities together and monitor how things are done, for example following up staff trained in various skills. MCSP gives trainings and allowances when we are involved in their programs. Even in the planning process, they helped us include programs that we had earlier planned for but were not done…."* *"…MCSP has visited and helped us with CoC plans; how to line up the programs, how to implement them. They came to orient us on SQA. Community engagement meetings. During ICCM trainings we had a representative from MCSP. During MDSR meetings…"* Some facility level informants also reported receiving TA from MCSP during onsite support with the district in areas such as labour management, community engagement and use of certain checklists; *"…They came with the district to support implementation…"* *"…They showed us how to write guidelines to stick in labor ward. Provided the facility with materials like pregnancy wheels…"* *"…TA on vaccine storage and management. Administered UCI checklist. TA in Community engagement…"*
Challenges with TA provided	<u>Summary Findings:</u> 90% of the district informants had no challenges with TA provided by MCSP. Inadequate transport was the only challenge cited by one district. Some districts and facilities lacked clarity on the role of MCSP 90% of facility level informants said they had no challenges with TA provided by MCSP. Most district and facility level informants reported no challenges at the district apart from inadequate transport to support field visits and lack of clarity on the role of MCSP among some facility level staff: *"…When activities end when they were not planned to Transport, they only have one vehicle so when it is out we have to support them with a DHO vehicle which can be quite inconveniencing…"* *"…..as a district we may plan to do an activity and if MCSP has other commitments during that period, as a district we will proceed to conduct an activity without MCSP been available Some program officers from the DHO don't understand what MCSP is here for, this was evidenced by what we experienced during the tour of Dr. Nambao and the team…"* Majority of facility level staff said they had no challenges, however one facility staff indicated that they needed to know more about MCSP and their focus:

Theme	Main Findings
	"….We need to know their strategies, for example we know SARAI is dealing with family planning, so we usually call them but for MCSP just the Monitoring and Evaluation Officer…."
Funding –MCSP	<u>Summary Findings:</u> All the districts and facility level informants indicated that it was not a challenge that MCSP is not funding activities directly. Facility staff indicated that districts have received support in terms of transport and equipment hence resources still reach them. District indicated that they did not have any challenges with the fact that MCSP was not funding activities directly because they understood the role of MCSP, support required is not always money *"…..From the word go we understand that their role is to give technical support…."* *"…..Because it is not always that we need money to support us in activities, mentorship is also a form of support….."* *"……That is the proper way because they monitor and encourage us to use G2G money well, i.e. for the intended purpose. We actually appreciate their role…"* *"….It is a very helpful because this is the first time we are receiving these funds and MCSP is providing guidance on how we should use them…"* One facility informant indicated that it was a challenge that MCSP was not directly funding activities because they were not giving allowances, however the majority appreciated the TA and the support given even if it did not include finances: *"…I understand that support is not only in form of money, even just information is helpful…"* *"…No because we are benefiting indirectly through the district. We received 2 vehicles and 1 ambulance…"* *"…For example the pregnancy wheels they provided help us calculate gestation quickly…"* *"….I understand that support is not only in form of money, even just information is helpful…"* *"….Because they are able to support technically and add to our knowledge…."*
Unmet TA Needs	<u>Summary Findings:</u> Districts have TA needs, but in most cases districts do not request for TA from MCSP. All districts level informants indicated that some TA needs are due to changes or movement of people and existing gaps in some areas, hence TA gaps will always exist. Facility level informants cited equipment, material needs and financial support as some of the areas that the TA did not cover. Provincial informant indicated that the challenge was mainly the late disbursement of funds; *"…..Last year we did not receive direct G2G funding but so far all districts have received 1st tranche for 2018,In implementation, we discovered that we need equipment, for example*

Theme	Main Findings
	people have been trained in EmONC but there's no equipment it would have been helpful if MCSP had a little funds to purchase some of these things…" District level informants indicated that areas for TA still exist in areas such as planning and capacity building: *"…With regard to the planning process, there is a lot of movement of program people therefore we require MCSP to guide during this process…"* *"…..More mentors trained in mentorship skills (we only have 2 trained mentors).Support in nutrition, for example Community Health promoters need re-training. Community volunteers also need training …"* *"….The situation has been that sometimes the districts don't ask for support from MCSP.."* *"…. Planning - Our indicators are not that good, most of them are in Red, thus with coming of MCSP they are gradually improving but we need more assistance because some indicators were under budgeted for the 2018 plans, for example child health, the amount we planned is less than the actual amount needed. Trainings – instead of bi-annually it would help to have them quarterly. Materials – such as FANC commodities to improve the early booking indicator and mama packs to encourage women to be coming to deliver from facilities…"* Facility level informants also shared that support is required including financial support: *"….In labor ward we required 1 delivery bed and a lockable cabinet…"* *"…. Allowances for staff at the facility. Staff lack information on how best to carry out child health and immunizations, maternal health….."*
Results- Effective TA	<u>Summary Findings:</u> Provincial informant cited mentorship and facility support visit as most effective technical strategy as they help in giving targeted support. District level informants cited facility support visits (67%), SQA (17%), community engagement (17%), mentorship (17%) and DIM/Data review (17%) as the most effective technical strategies because they help build capacity onsite and ultimately improve the indicators. 60% of the facility level informants cited facility support visits as the most effective strategy because they receive onsite capacity building. Provincial level informant indicated that mentorship and facility support visits are effective because they give targeted support: *"…..During data review, some performance gaps are identified then a mentorship program is designed to try and address those identified gaps together with MCSP,From time-to-time MCSP usually sample some facilities and look at the programs provided and challenges being faced together with respective DHO program officers. MCSP also implements community programs together with DHO staff…."* District level informants indicate that mentorship, facility support visits and community engagement, DIM/data review are the most effective technical assistance strategies: *"…..SQA has helped the district to identify some gaps where we need to improve with planning, and assess our performance as a district……Community engagement is another strategy with is helping to reach our communities in a systematic manner so that the health care services reach the intended and correct population…."*

Theme	Main Findings
	"…..Most of the technical support given is being conducted in the facility…." *"….Because in mentorship, someone is on the ground with the mentee, discuss find problems and clarify issues together unlike teaching where you just talk…."* *"….Facility support visits help us improve indicators for example skilled deliveries in facilities. Transport because without this, it is difficult for us to visit facilities…."* *"….Hands on* *For example how to arrange certain things in a facility, after this TA from MCSP, we have been able to practice what we learn in facilities even here at DHO. MDSR Meetings Recommendations were given and we have worked on them. For example Kafutuma RHC has contributed a lot of maternal deaths to St. Paul's Mission Hospital and from that MDSR meeting, we brought on board more SMAGs…"* *"…. HMIS and dashboard use Helped set a base for decision making…Facility visitation Helped the district know what is on the ground…"* Facility level support was the most effective because of the onsite support, capacity building the facility staff get from MCSP: *"….It was helpful when they came with district staff to talk to staff at the facility…"* *"….Guidelines and charts when they come…"* *"….During the facility visit, they monitored our vaccine fridge and through their TA we appointed someone to be monitoring temperature. It is now easy for us to come up with activities to implement because of the micro plans they helped us come up with. They gave TA to integrate child health services so that children are screened in full so that we identify different conditions in children…."*
Results in HCWs Skills	<u>Summary Findings:</u> Provincial informant indicated that MCSP TA has improved HCWs skills as some indicators are improving 83% of district level informants indicated that MCSP TA has improved DHO skills though trainings in areas such SQA , mentorship, support visits, orientation of staff, 60% of facility level informants indicated that MCSP TA has improved the facility staff skills through material support, guidelines and onsite support and orientation. Provincial level informant believe HCWs skills have improved *"….So far so good, we seem to have improved in areas like maternal deaths are reducing compared to previous years, still births are also reducing and teen pregnancies are reducing though this one is debatable because numbers may be increasing because it puts programs in place and captures more adolescents, immunization programs have also improved above 80% for most districts; even Mansa has picked up compared to the past were it used to score below 80%. We will evaluate fully when the year comes to an end by looking at indicators for 1st and 2nd quarter We may not be reaching targets in most areas but at least improvement is there…."* District level informants indicated that TA has helped them improve skills in areas such SQA, mentorship, orientation and this has impacted positively on service delivery:

Theme	Main Findings
	"…..MCSP has helped the DHO to do SQA and mentorship and this has improved the skills of the staff. For example during the planning process, we are able to know where we are not doing very fine and we concentrate our efforts and resources there….." *"…..Because like for example in child health immunizations, when we make a follow up we find that staff have worked on what has been agreed upon. Staff are able to change certain things there and then during TA…"* *"….We have conducted orientations and trainings to staff who were lacking some skills and this has improved indicators such as early booking and skilled deliveries…."* *"…Usually after TA, we note a lot of improvement in facilities for example in the area of complete data capturing…"* *"….Facility staff appreciated mentorship and TA and this has improved service delivery…"* Facility level informants shared that skills have improved due to the TA provided that included support with materials such as guidelines, orientation in certain procedures: *"….Some manuals were brought on issues to do with vaccines which have information that has helped us…"* *"….The charts and guidelines provided in labor ward have helped staff avoid avoidable complications when women are in labor…."* *"….Before MCSP came to our facility to offer TA, we used to overlook certain things because they would appear small like following guidelines when screening children…."*
Results in Implementation of HII	<u>Summary Findings:</u> Provincial level informant indicated that MCSP TA enabled the province plan for high impact interventions through the material and technical support they offered. 80% of the district level informants indicated that MCSP TA enabled the district plane for high impact interventions through sharing information, logistical support, identification of activities, follow ups 40% of facility informants agreed that MCSP TA enabled facility implement high impact interventions as they have been able to implement some guidelines, and increased coverage Provincial level informant indicated that MCSP has helped in ensuring high impact interventions are planned by providing technical and material support: *"….We have had material and technical support from MCSP. Spot checks have been helpful but not all issues are covered under RMNCAHN programs because of ceilings so back up finances from MCSP would be good…."* District level informants indicated that MCSP has enabled them plan for high impact interventions through follow ups and sharing of information: *"….We have managed to include some high impact interventions, however we are a bit behind because some program officers don't like delegating to others and MCSP is here to remind us that we are behind….."*

Theme	Main Findings
	"…..Because we have been equipped with information therefore we are able to improve indicators. Also, transport provided to reach mothers and facilities…" *"….We have started but unfortunately we received funds late thus some activities have been moved to be done later.We have planned for mother's shelters in areas where mothers walk long distances to deliver…"* Some facility level staff indicated that MCSP TA has helped them implement high impact interventions in adolescent health and child health. However, some indicated that they have not seen MCSP provide any support to the facilities: "….For example distribution of condoms and dissemination of information to youths which has led to a high turnout of youths at the facility…" "….We have been able to implement activities in line with UCI guidelines and have been able to see more children…"
Results in Community Engagement Systems	<u>Summary Findings:</u> The provincial level informant indicated that MCSP helped in improving community engagement systems by providing guidance to program teams. 67% of district informants agreed that MCSP TA has improved community engagement systems through monitoring, engagement of stakeholders and advocacy for community participation. However, 33% of the districts informants indicated that they have not seen any MCSP support in community engagement. 80% of the facility level informants indicated that MCSP has not helped in improving community engagement systems The provincial level informants indicated that MCSP has helped in improving the community engagement systems by providing guidance: *"….MCSP has provided guidance to districts to ensure programs targeted at the community, through TA they provide guidance to districts to cover community programs for example an indicator under nutrition on stunting has high figures the whole province, MCSP helped tailor our trainings to target community based growth monitoring groups so that they can provide services in line with guidelines, SMAGs in other districts, peer educators. MCSP is ensuring that issues to do with the community are addressed…"* Some district level informants indicated that MCSP TA has improved community engagement systems, though some said it has not: *"…..Although we still have a long way to do because MCSP will just provide the TA and it's the districts that need to provide support to the community. Example of what was happening in Petauke. MCSP has done their part and what is remaining is the district to do their part since funds are with us….."* *"…. MCSP helped us through monitoring how we are calling on the community to help us boost indicators, for example SMAGs…."* *"….This is when we have started improving community engagement systems and we share facility indicators with stakeholders (community)….."* *"….They emphasized on the need to involve the community and since then the district has taken a step to ensure the community is always involved…"*

Theme	Main Findings
	Some district informants indicated that MCSP has not done much in terms of community engagement *"…We have not seen much of community engagement technical assistance to community volunteers. In the RMNCAHN scope we have received more support in maternal and child health…"* Most facility level informants indicated that MCSP TA has not helped improve community engagement systems: *"…So far no community engagement systems have been improved…"* *"…So far community has not been involved…"* *"….We are not in direct contact with them…"*
Recommendations	<u>Summary Findings:</u> MCSP should have a budget to support some activities that need support and are not budgeted for. MCSP and DHO must develop joint plans and provide joint TA to the districts. Facility staff need to be involved in identifying areas that need TA. Need to increase coverage for TA to facilities and frequency Provincial level informant recommended that MCSP should have small budget to address gaps missed out in the G2G plans: *"….It would be important for MCSP to be given a small budget to address some issues that would be left out under G2G plans….."* District level informants recommended that there was need for joint plans, strengthen follow ups on TA provided and increase frequency of TA: *"….Joint plans where we need to share plans and know when which activity is taking place at what time MCSP to have a staff based at DHOs for easy communication and support MCSP to have some leeway in their plan so that they should be able to do something on their own……"* *"….Can identify gaps by the facilities so that guidance can be given to partners on areas and facilities to target. Adolescent is still lagging behind therefore the district needs a lot of technical support in this area. Terms of reference and roles for community volunteers…."* *"…..Train mentors from each facility. Follow up trained mentors quarterly or bi-annually. Train some community volunteers especially Neighborhood Health Committees. Help the district organize the above trainings…."* *"….Money can be coming through MCSP instead of waiting for it to come directly from G2G.If MCSP also had money to implement some programs along with technical support for example materials like under 5 cards, nutrition commodities. During planning, MCSP can through our plans with us just to ensure everything is adequately budgeted for and nothing is missing …"* *"…. Have a TA schedule, for example quarterly, monthly for frequent follow ups to see improvements, Continue using different TA strategies, Standardized tools in TA provision, Involve staff at both DHO and facility level, Facility learning visits, Capacity building where gaps are identified, Mentorship…."*

Theme	Main Findings
	Facility level informants shared a number of recommendations that ranged from the need for their involvement, increase in frequency of TA visits, involvements of communities, increased coverage for trainings: *"….Facilities to be involved in what they are doing so that we know exactly what they do.Senama needs to be visited as a center so that we know the strategies they are implementing. We are at the grass root therefore, we can have direct contact with staff from MCSP…."* *"….Increase frequency of TA visits. Calling for a training on maternal and child health…"* *"….Involving the community as it is key to the development of RMNCAHN indicators; have meetings/orientations/trainings with them.MCSP should be visiting this facility quarterly so that we discuss challenges and performance…."* *"….Under child health activities, MCSP can assist the facility with weigh (outreach) structures. Assist the facility with equipment like weighing scales, weighing bags for the 10 zones that the facility has. Extend technical support to community based volunteers, conduct trainings for them as a way of motivating them…"* *"…..The facility has been split into two, thus most staff are housed at the hospital which makes service provision difficult. Staff from here to be included in trainings to improve skills, for example GMP, EmONC,Volunteers to be considered for trainings, Equipment for delivery room like oxygen, sucker needed…."*

2.4 Muchinga Province

The following summary table has been compiled from the qualitative research conducted in Muchinga province over the period 16th – 21st July 2018. It is based on some summary findings from interviews at provincial, district and facility, as well as the sampled health facilities

Table 6: Summary of Muchinga Province Interviews

Theme	Main Findings
Awareness	Summary Findings: All provincial, district and facility level staff have heard about MCSP and described it as a project funded by USAID working on RMNCAH&N programes All the district level informants agreed that relationship exist between CoC and RMNCAH&N exist as they both focus on improving maternal and child health. The provincial level informant has heard about MCSP and described it as a USAID project providing technical assistance on RMNCAH and N. A relationship exists by MCSP and COC *"….MCSP is a USAID funded project which is rolling out technical assistance on RMNCAH&N program…"* *"….MCSP is a USAID funded project which is rolling out technical assistance on RMNCAH&N program…."* All the district level informants have heard about MCSP and described it as a USAID funded organization providing technical assistance on RMNCAH&N. All the districts level informants also indicated that a relationship exists between MCSP and CoC, however a 40% did not clearly explain the relationship.

Theme	Main Findings
	"…Knew it last year in October 2017. It is working on RMNCAHN activities and indicators to improve on maternal and child health as well as help to offer mentorship in RMNCAHN…." *"…MCSP is a USAID supported program that offers technical assistance on RMNCA&N activities. They support facilities through visits to offer assistance on RMNCAH&N indicators and activities. Helped/supported Kanchibiya during the planning process as well as the revision of the G2G 2018 plans…"* *"….A program which is providing technical assistance on the RMNCAH&N program…."* *"…Provide technical assistance on the G2G program/activities and its demand driven…."* *"…Working on indicators based on reproductive health, adolescent health, maternal health and child health. Program giving mentorship to health workers on RMNCAH&N….."* *"…..Both provide technical support on the RMNCAHN activities but MCSP provides technical assistance model…."* *"…..MCSP supports the districts improve the RMNCAH&N indicators…."* All facility level staff have heard about MCSP and described it as an organization as an organization focusing on supporting maternal and child health: *"…A program that deals with protecting mothers from maternal deaths. Deals with neonates as well as ensure children get full vaccinations…"* *"…It deals with maternal and child survival. Looks at sensitization of mothers to come early for antenatal…"* *"…Working hand in hand with G2G to check on how activities are implemented…"* *"…. Looking at maternal health, child health and nutrition activities. They support the facility through facility visits…."*
MCSP Technical Support	<u>Summary Findings:</u> The provincial level informant and all the districts and facility level informants indicated that they have received TA from MCSP in the last 6 months The district level TA included mentorship, revision of plans, supportive visits Facility level TA included mentorship, data review and trainings in HMIS The strategies engaged at districts and facility level included mentorship, community engagement, data use for decision making, data review and CoC planning. All districts have received TA in the last 6 months that focused on mentorship, supportive visits and review of the G2G plans. The technical strategies deployed included community engagement, data use, mentorship and CoC planning; *"……Received TA support where MCSP with the district provided mentorship to facilities in the labor ward and maternity ward. During last year child health week, they supported us with logistics and transport as well participated in planning implementation of this activity….."* *"…..During planning, they provided TA do revise/reschedule the G2G plans; Implementation, they ensured TA is provided by looking at the quality of service/activities implemented…"* *"……They provided mentorship in some health facilities to the health workers in different RMNCAH&N activities; Provided TA in the implementation of the focused ANC services; Received TA during the DIM and 2018 planning process on the RMNCAH&N activities…."*

Theme	Main Findings
	All the facilities have received TA from the MCSP in the last 6 months that included mentorship, training in registers, data review and onsite support. The strategies used include mentorship, data use for decision making, community engagement, CoC planning and facility support visits. *"…..MCSP staff visited on a number of times especially in the labor ward to provide mentorship to health workers there. Received feedback after the technical support visit from MCSP staff. Received mentorship on the RMNCAH&N quality service……"* *"…..During child health week; they monitored the activity and later guided on how to mobilize for more clients. The other one was on the new registers where they helped to orient and understand the new registers….."* *"….During facility visit; supported to intensify integrated outreach programs. Received supported on the improvement of the ORT corner…"* *"…..MCSP offered technical assistance support during the review of the 2018 G2G plans. Hence reviewed G2G plans together. MCSP ensured that the G2G activities planned are implemented according to the given guidelines. During maternal death reviews; they offer technical assistance to the hospital on the gaps identified and offer recommendations to have zero maternal mortalities. Received mentorship in labor ward…."* *"…. Received support in data review in the MCH and labor ward departments. Storage of vaccines at the facility and temperature monitoring…."*
Challenges with TA provided	<u>Summary Findings</u> 80% of the district and facility level informants said they did not experience any challenges in receiving from MCSP One facility informant however, indicated that the presence of MCSP at facilities is limited, no appointments are made and inadequate time is spent at facilities The provincial level informant indicated that there was no challenge in receiving TA from MCSP: *"…..Do not expect the external support in full. This RMNCAAH&N program is also implemented by GRZ, however MCSP is just providing TA on it…."* The district level informants indicated that they did not experience any challenge in receiving TA from MCSP *"….As long as they are here to provide TA on an activity on time…"* *"….Usually this is an organization which just follows-up on the planned activities budgeted under G2G……"* *"….Because after the understanding of the funding mechanism, it's easier to understand that MCSP does not provide funding but TA only…"* *"….As long as the districts receive the direct G2G funds, MCSP role is to provide demand driven TA……"* *"….Expect the partners/MCSP to provide some direct financial and transport support on urgent gaps identified as opposed to waiting for funding in the next budgeting year…"*

Theme	Main Findings
	Most facility level informants said they have not experienced any challenge in receiving TA from MCSP. However, one informant indicated that MCSP's presence in facilities was limited and they spent less time in facilities. *"…..Little/limited presence of MCSP staff at the facility because they are few…"* *"…except they come when the facility staff least expect the MCSP staff. However, they are given time to work with the facility staff for the benefit of the community. Inadequate time spent with the facility staff…."*
Funding –MCSP	<u>Summary Findings</u> The provincial level informant indicated that it was not a challenge that MCSP was just supporting activities and not funding activities, as MCSP was just providing TA. 80% of the district level informant did not see it as challenge It's not challenge for most district staff (4/5) that MCSP is not directly funding CoC activities as long as districts receive the resources directly. MCSP is focusing on providing technical support. 80% of facility level informants indicated that it was not a challenge that MCSP is not directly funding CoC activities because not all activities require resources and activities are already funded Facility level staff understand the role of TA Some facility and district staff want MCSP to have resources to support some activities. The provincial level informant indicated that the MCSP funding approach is not a challenge: *"….Do not expect the external support in full. This RMNCAAH&N program is also implemented by GRZ, however MCSP is just providing TA on it……"* Most of the district level staff indicated that it was not challenge, however, some suggested that MCSP should have resources to fund some activities in the districts: *"…..expect the partners/MCSP to provide some direct financial and transport support on urgent gaps identified as opposed to waiting for funding in the next budgeting year…"* Facility level staff also understand that MCSP provides TA and resources are provided directly to the districts: *"…Because it's not everything that needs funds but advise is sufficient enough for the staff…."* *"…. It does not pose any challenge because the activities are already funded and don't take away anything but the facility greatly benefits from their technical assistance support…."* *"….Because the districts was already funded through the G2G to implement the activities and MCSP role is to provide TA…."*
Unmet TA Needs	<u>Summary Findings</u> Provincial level informant indicated that all the TA needs were addressed by MCSP. 40% of the district informants indicated that TA needs still exist that were not addressed by MCSP TA which include capacity building. 40% of facility level informants indicated that TA needs still exist that were not addressed by MCSP TA at facility level mostly in mentorship in areas such as nutrition. The provincial level informant indicated that MCSP addressed all TA needs:

Theme	Main Findings
	"…Most needs identified were addressed…" Some districts level informants indicated they still had TA needs that were not addressed which included capacity building and follow up on gaps identified and shared: *"…As a district, nursing officers were told/submit gaps to MCSP so that their technical support can come in but it took/never too long to receive that support…"* *"…MCSP promised to conduct a mentorship training to program officers but this capacity building venture has not been addressed…."* Some facility level informants indicated they still had TA needs that were not addressed which include mentorship and support in mentorship and MCH: *"…. Nutrition area; no one at the facility has received mentorship/support in nutrition. Documentation especially in the labor ward was not addressed or stressed…."* *"…More on-site mentorship. Get more involved with what happens in the wards meaning there should have more manpower…."*
Results- Effective TA	<u>Summary Findings</u> Provincial level informant indicated that the most effective strategies are mentorship and CoC planning District level informants cited mentorship (80%), DIM/Data review (60%), data use for decision making (40%), CoC Planning (60%), community engagement (20%) and facility support visits (20%) as the most effective strategies. They are effective because they enhanced identified of gaps and interventions including new strategies. Facility level informants cited SQA (20%), mentorship (40%), facility support visits (20%), community engagement (20%), CoC planning (20%)and data use for decision making (20%). The strategies are effective because they are interactive. At facility level TA was given in outreach, child heath, and CoC planning. Provincial level informant indicated that the most effective strategies are mentorship and CoC planning Most district level informants indicated that the TA was effective as it helped in identifying the gaps, interventions and new strategies; *"…Mentorship although the challenge is that it is not continuous/constant. Data review meeting because there is still a gap in the facilities to analyze the data…"* *"…Monitoring the activities/achievements in the facilities, advise received on planning is a nice because it enhanced high impact 2018 activities…"* *"….Moving through the problems to greater and find solutions which translates into greater care on the client/community; Link the challenges with the data and come up with solutions; Coming up with community structures….."* *"…..Mentorship; staff are followed up in the facilities of activity implementation, find gaps and provide solutions together. Participation in the data review meetings broadens the capacity of DHO staff to review the data. CoC planning TA sharpened the understanding of how to implement high impact interventions and prioritize activities…"*

Theme	Main Findings
	"…Developed new strategies to do review data from business as usual to new things like bottle neck analysis….." Facility level informants indicated that the TA was effective because it was one to one engagement, it covered how to conduct outreach and data usage: *"…..One on one interaction is very important because it encourages health staff to do what are supposed to do and follow protocols…"* *"……Previously never used to give IEC messages during outreach but after orientation by MCSP/TA given, the facility is able to give IEC messages now…."* *"….The one where we put the stock control cards and ORT corner. Intensification of integrated outreach programs…"* *"….Because most of the planned activities in the 2018 G2G plans are effective and achievable which are now been implemented. Helped the facility develop realistic interventions which could reduce the maternal mortalities. Helped establish a good referral system with the facilities to ensure gaps are closed up to reduce maternal deaths and serve clients better…"* *"…. Improvement in the data reviews and data use storage and management. With the scorecard mentorship, staff are able to do a self-assessment to show their progress and improvement…."*
Results in HCWs Skills	<u>Summary Findings:</u> Provincial level informant indicated that MCSP TA has improved HCWs skills because there is a change in how things are done. 80% of the district level informants indicated that MCSP TA has improved HCWs skills through mentorship, onsite support in planning District level skills have improved in identification of gap, planning, data management. All facility level informants agreed that HCWs skills have improved specifically in community engagement, interactions with patients and infection preventions skills Provincial level informant agreed that MCSP TA has improved HCWs skills because after the TA, the way things are done improves: *"…..After a review there is departure from business as usual to providing or doing high impact interventions…"* All district level informants indicated that HCWs skill have improved due to the TA that has resulted in improved in identification of gap, planning, review of implementation, and data management: *"…Some health workers because lately the district received new staff and as a district there is no time to orient/train them; Hence, MCSP TA model provides the chance for mentorship to these new staff…."* *"…. They are more focused, planning has improved, The M&E component has improved as well…."* *"….The TA has gone to the facility and community to understand the implementation of CoC activities…"*

Theme	Main Findings
	"…. Especially at facility level, MCSP has provided more TA HCWs in data management, evaluation and able to display data on RMNCAH&N indicators…" *"…. Skills developed to do the planning process and identify gaps. Mentorship has shown the right way of providing quality of service…"* All facility level informants indicated that TA has improved the HCWs skills. *"…However, it depends on one's individual attitude to learn the skills been transferred to them. Because of attitude other prefer not to learn…"* *"…Partially; especially when it comes to reminding HCWs to give IEC messages before service delivery…."* *"….Because one staff was able to orient the community on the Z-scores and identify a malnutrition child….."* *"…..Especially the on-site orientation in the labor ward and nutrition wards…"* *"…. Especially on the infection prevention has greatly improved. Skills to handle the malnourished children has greatly improved…."*
Results in Implementation of HII	<u>Summary Findings</u> TA has introduced high impact interventions in nutrition, community engagement and child health at facility level. 80% of the district level informants indicated that MCSP TA has enabled the districts to implement high impact interventions in RMNCAH&N. 60% of the facility level informants agreed that MCSP TA has enabled the facility implement high impact intervention in RMNCAH&N. TA at district has also contributed to introduction of high impact interventions in maternal health, community engagement. TA was provided during CoC planning District level staff indicated that MCSP TA had helped introduce high impact interventions in maternal health, *"…. Districts looks at high impact interventions that will improve indicators, planning for the CoC has improved linkage of the indicators…."* *"….MCSP TA enabled the districts implement maternal deaths reviews in a systematic way and facilities have reduced on maternal deaths in the first two quarters of 2018; MCSP TA provided to open up more outreach posts which enabled the district to improve on immunizations and fully immunized…"* *"…..The plan that the district is implementing is actually from the TA MCSP provided on during the revision of the 2018 G2G plans and an upward increment of the indicators…."* *"…..Partly; wish they could go to all the facilities…"*

Theme	Main Findings
	Some facility respondents indicated that TA has helped facilities implement high impact interventions in community engagement, child health, and nutrition *"…..They are trying; sensitization on hospital delivery through SMAGs trainings. SMAGs produce reports now as well as receive feedback. Postnatal which was very bad as improved through the messages by SMAGs…."* *"….The EMONC trainings will help the facility reduce the maternal mortalities and other related deaths. With the IMAM training, staff will be competent enough to handle malnourished children and increase care. Contributions in the PNMDSR meetings yielded high impact interventions which range from team work to the referral systems…."* *"…..GMP has greatly improved by identifying the malnourished children. Reduction of the infection prevention in the labor ward to improve quality of service…."* Some facilities on the other hand indicated that they are implementing activities not introduced by MCSP *"…The interventions we are using now are not as a result of MCSP but just initiatives the facility came up with…"*
Results in Community Engagement Systems	<u>Summary Findings</u> Provincial level informant was not sure if MCST TA has improved community engagement systems. 60% of the district informants indicated TA has improved community engagement systems through trainings of SMAGs and sensitizations on community engagement strategies at district level. TA in trainings and meetings have also contributed to community engagement systems strengthening. 80% of facility level informants indicated that MCSP TA has improved community engagement systems. TA has contributed in strengthening community engagement systems through SMAG trainings, onsite TA and contributions during meetings Provincial level informant was not sure if MCSP TA has improved community engagement systems: *"…As PHO we continue engaging the community on various RMNCAH&N activities, hence do not know if the is attributed to community engagement systems…"* District level informants indicated receiving TA from MCSP that focused on trainings and sensitization on community engagement strategies: *"…..Through the recent trainings in SMAGs and community RBF, the community is been engaged but not in all facilities because NHCs are still being revamped. Looking at the indicators the district is tracking, more women are coming early for antenatal, children taken for GMP and other services due to the orientation received…."* *"…..During DIM, MCSP made presentations on community engagement strategies where all the health Centre in charges were available and the message was well taken and all facilities are implementing that…"* *"…. Community structures that went to sleep have now been revamped…"* However, one district staff shared that the district was not aware if MCSP supports community engagement activities *"…Because staff is not aware if this service is provided by MCSP…"*

Theme	Main Findings
	Facility level informants indicated that MCSP TA contributed in strengthening community engagement systems through SMAG trainings, onsite TA and contributions during meetings *"…..TA emphasized that we improve on facility delivery and restructure the community-based activities. Organized meetings with key community gate keepers…."* *"….On the sensitization part; when mothers come for Under 5 IEC messages are given to mothers which they later on take to the community. Revamped NHCs structures to deliver important message s to the community…"* *"…. Communities are having frequent meetings now and having more activities…"* *"…. NHCs help to take the RMNCAH&N messages to the community…"* *"…No much engagement with the facility on community systems…."*
Recommendations	<u>Summary Findings:</u> Structure for TA model should be intensified. MCSP should work closely with DHO Schedule activities together with district to provide TA MCSP TA coverage for facilities to be increased Promote sharing of data and involvement of MCSP meetings such as DIM Provincial level informant recommendations are that the structure for TA model needs to be intensified: *"…. Continue providing TA model and intensify the structure of this TA model…"* District level recommendations included the need for MCSP to consistently work with DHO, developing schedule and focusing on staff working on RMNCAH&N: *"…..Work hand in hand continuously with DHO maybe on monthly basis. Consistent visits will motivate staff in health centers…"* *"…. Coming up with a program/schedule for the team that is visiting Kanchibiya, Continuous/frequent visits will motivate/encourage the staff at facility and DHO level…."* *"….Roll out the TA to most of the facilities other than sampling of few facilities; Having frequent and consistent meetings with DHO and facilities…."* *"…. Providing TA to program officers especially those providing RMNCAH&N activities at DHO, Specific program officers at DHO to escort or accompany MCSP staff in the facilities to provide TA; During DIMs, MCSP to have access to the data performance of the districts prior to district and facility presentations so that they help bridge the gaps in the underperforming indicators…"* *"…. Have a plan like quarterly to show MCSP work-plan and a schedule when they will visit the districts…"* Facility level informants recommended that MCSP needed to make appointments, agree on areas of focus and ensure there is frequent interactions: *"….. SQA is still recommended however, they should set appointments with the staff like days/weeks before visiting the facility. Set sessions on the topic to talk about…."*

Theme	Main Findings
	"…. TA model to be extended to the NHCs/community structures. Frequent/consistent TA visits to improve. TA model should be extended to all staff; it should be multisector…." *"…. Facility to be informed prior to MCSP coming for TA so that they organize a bigger group. Organizing the TA in departmental areas…."* *"….More trainings will be needed. Exchange visits to other facilities so that they receive new updates from our colleagues…"* *"….MCSP has been helpful to the facility and they still have more to do because their goal of reducing or ending maternal deaths has not been realized…."* *"…. Have MCSP staff stationed at the facility to provide more on-site mentorship. Presence of MCSP staff during the entire process of planning cycle. Get involved in the planning of the GRZ MTEF funds…"* *"…. MCSP staff to regularly meet the health worker staff at the facility. Extend direct financial support/funding to the facility…"*