Moyo wa Bana (MWB) Integrated Management of Child Illnesses Project Phase II

Final Evaluation Report

CIDA Project #4278-21013

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819-459-3705

April 10th, 2006

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ALRI	Acute Lower Respiratory Infections
ART	Anti Retroviral Therapy
CDN	Canadian
CBOH	Central Board of Health
C-IMCI	Community-based Integrated Management of Childhood Illnesses
CDPF	Country Development Program Framework
CIDA	Canadian International Development Agency
CHPs	Community health promoters
DAPs	District Action Plans
DHMT	District Health Management Team
EPI	Extended Program of Immunization
FP	Focal Point/Person
GMPs	Growth Monitoring Points
GRZ	Government of the Republic of Zambia
HIPC	Highly Indebted Poor Countries [Initiative]
HIV	Human Immunodeficiency Virus
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
LFA	Logical Framework Analysis
MCH	Mother and Child Health
MoH	Ministry of Health
MTCT	Mother to Child Transmission
MWB	Moyo wa Bana
NGO	Non-Governmental Organization
NHCs	Neighbourhood Health Committees
ORT	Oral Rehydration Therapy
PAD	Project Approval Document
PBAs	Program based approaches
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
RBM	Results-Based Management
STIs	Sexually transmitted infections
SWAPs	Sector wide approaches
TBD	To be determined
TORs	Terms of Reference
UCI	Universal Child Immunization
WBS	Work Breakdown Structure

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Executive Summary

The current Moyo wa Bana (MWB) Project Phase II (2001-2006) aims to assist Zambia to improve the health of under-five children using the integrated management of childhood illnesses (IMCI) approach, particularly in relation to the prevention of malaria, diarrhoea and Acute Lower Respiratory Infections (ALRI), with a budget of $5M CDN. It operates in three areas of Zambia: Kasama in the Northern Province, Ndola in the Copperbelt Province and in the capital region of Lusaka. MWB works with the District Health Management Teams (DHMT) and the Central Board of Health (CBOH). The project targeted approximately 225,000 under-five children and over 350,000 care providers as indirect beneficiaries of the project (reached via direct beneficiaries in the health sector and communities).

The external evaluation was conducted in January/February 2006 by Ms. Anne Gillies, Team Leader and Dr.Christine Kaseba, Health Specialist, via a field visit to selected MWB sites Zambia and review of key contextual and project documents. The main aims of the evaluation were to: 1) review the project context; 2) determine progress towards developmental results (outcomes and outputs); 2) analyze management and operational effectiveness; and 4) provide recommendations that would assist in design of a further phase.

Main Findings and Conclusions

The evaluation found that the project directly reached approximately 3,790 CHPs, 271 THs, 596 NHC members and 511 health workers/supervisors who were trained in conducting IMCI activities via the project, across 47 clinics/communities in three districts. Achievement of developmental results, cost-efficiency, partnership, appropriateness of design and informed and timely action were all good.

The following are the main findings and conclusions of the evaluation:

- The project had many *positive effects* on the health of under-5 children and on access to high quality IMCI services in the targeted districts and clinics. In some areas, *the morbidity rates for under-5 children either stabilized or were reduced for diarrhoea, malaria and ALRI.*
- MWB demonstrated how the community component of IMCI could be effectively implemented through an *integrated, multi-level approach*, including *influencing the skills and knowledge of caretakers* about how to prevent common childhood illnesses, *improving the scope and quality of health worker training, improving IMCI case management and referrals* for targeted districts, and *engaging community volunteers* as key resources and actors in child health. As well, the project had some strategic influence on the national health system's approach to IMCI, through helping to *improve IMCI training methods* and *through providing input to IMCI strategy development.*
- The project was *less successful in demonstrating that replication and roll-out of comprehensive IMCI by the Zambian health system can be sustained in the long-term*. Although supervision and planning was strengthened at the clinic level, the project was not able to ensure full transfer of IMCI management to the District Health Management Teams in areas where it worked. The project was weakest in terms of specific strategies for organizational capacity building.

The evaluation team's conclusion is that MWB Phase II was a strong project, and that its inability to fully achieve some planned results was to a large extent due to contextual and institutional factors outside the project's direct control. However, there are continuing risks that the benefits so far may disappear or attenuate over time without a rigorous strategy for more intensive and multi-layered capacity building support for the GRZ in IMCI management and improved donor and government resource allocation for child health, especially at the provincial and district levels. In the opinion of the evaluation team, a future phase is fully justified but will require much more intensive investment and coordination from both CARE, CIDA and GRZ partners to ensure that it provides a viable and sustainable contribution to the Zambian health sector by linking project-based support to broader health system reform, funding and policy initiatives.

Recommendations

The following points provide a synthesis of the key recommendations from the evaluation.

A. CARE should do the following:

- place a stronger focus on finding techniques to build the capacity of the health system for replicating and sustaining the excellent strategies used so far for community volunteer engagement and empowerment;
- continue to research and document in future phases the issue of volunteer incentives at the community level by assisting the health sector to experiment with different models and approaches for use in IMCI;
- consider building in an operational research component (possibly in partnership with research institutions) to better document IMCI innovations and practices learned via the project;
- focus on ensuring that Zambian health partners can maintain the quality and consistency of IMCI case management practices among health workers (via training, refresher courses and quality checks), and analyze the incentives (both monetary and non-monetary) required for health workers to continue to implement IMCI and ensure that at least some of these incentives are built into health sector budgets;
- conduct institutional capacity assessments to identify assets and gaps in IMCI management at the provincial and district levels, provide technical input in strategic planning and budgetary processes to ensure that adequate resources and management systems are in place for IMCI, and ensure that the National IMCI Planning Guidelines are improved and applied consistently as required;
- focus on ensuring quality and sustainability of IMCI services well as on developing methods to ensure widest possible replication of comprehensive IMCI approaches by the GRZ (i.e. rather than investing directly scale-up by the project itself, focus on providing technical support to GRZ in planning and managing its own scale-up process);
- create a detailed, costed gender action plan that is fully integrated with the new project WBS, with appropriate technical resources on gender attached;
- focus attention in the next phase on ensuring that the recently-introduced HIV/AIDS checklist is fully integrated into on-going IMCI case management (through both refresher and new training with health workers) and that the checklist is consistently used by health workers;
- develop a closer linkage between programming and budgeting, create stronger, performance-oriented workplans and reports, and support project staff to obtain thorough knowledge and skills in RBM;
- design a system for both internal project performance measurement and to reinforce partner capacities in analyzing community health issues, that is as simple, streamlined and easy-to-understand as possible; and
- credit CIDA explicitly as a supporting donor in any documents, tools, or information released on IMCI where CARE (via the MWB project) has played a contributing role as a result of CIDA funding

B. CIDA and CARE should jointly do the following:

- ensure that any future phase of MWB is closely linked to new or on-going Canadian health sector investments, such as technical or financial support for PBAs, support for human resource development in the health sector and improved drug procurement systems;
- produce a new project design that is based on participatory, multi-stakeholder mapping of the project's performance logic, ensure that all results are clearly defined, realistic, achievable and measurable (particularly in relation to provincial and/or district capacity building and ownership), and build in a clearer distinction between primary and secondary beneficiaries;

- develop a new joint approach for planning and implementing more strategic, performance-oriented PSC meetings in future project phases;
- focus on establishing closer field collaboration mechanisms during the next phase of MWB to review project progress and decide how the information from project implementation can be used to either increase the strategic value of other CIDA investments in the health sector, and/or improve leverage for more resources and better policies for child health at the national level; and
- create stronger strategic linkages at the national level to divide up responsibilities and lobby with government and donors for improved IMCI allocations within central and district budgets.

C. CIDA should do the following:

- participate directly in various national policy working groups and committees on child health to advocate for adequate resources for sustainable, decentralized management of IMCI;
- contribute directly to PBAs in the health sector to leverage increased national and donor support for child health and ensure that project-level investments are financially and institutionally sustainable, including direct investments in district basket funds that are earmarked for child health and can be utilized at the district level to support the full spectrum of IMCI services and activities; and
- play a more active oversight, analysis and monitoring role in any future phase.

1. Introduction

1.1 Project Background

Moyo wa Bana means "the life or health of children". The current Moyo wa Bana (MWB) Project Phase II aims to assist Zambia to improve the health of under-five children using the integrated management of childhood illnesses (IMCI) approach, particularly in relation to the prevention of malaria, diarrhoea and Acute Lower Respiratory Infections (ALRI). The MWB Project also promotes HIV/AIDS awareness and behaviour change as a way of consolidating the health and survival of children through healthy parents.

The Project began in July 2001 and runs until April 2006 with a budget of $5 million CDN. It operates in three areas of Zambia: Kasama in the Northern Province, Ndola in the Copperbelt Province and in the capital region of Lusaka. The MWB project works in close collaboration with the District Health Management Teams (DHMT) and the Central Board of Health (CBOH). The project targets close to 225,000 urban and rural children under five (via its work to strengthen IMCI delivery by GRZ partners), as well as approximately 350,000 other household and community members.

The current MWB project has the following objectives:

- Reduced incidence of the leading cause of death among under-five children (malaria, diarrhoeal disease and ALRI as a result of: i) changed household practices; and ii) improved delivery of community-based health services by Community Health Promoters (CHPs), Neighbourhood Health Committees and clinics in the areas of malaria, ALRI and diarrhoeal diseases.
- Reduced spread of HIV/AIDS and STIs as a result of: i) changed individual behaviours (safer sex, seeking testing, counselling and treatment); ii) appropriate education and information from CHPs in collaboration with clinic staff; and iii) improved quality and scope of services and referrals provided by clinic staff.

To achieve these results, the project carries out activities which include: capacity building for health care workers in the delivery of IMCI; strengthening of the relationship between health centres and their catchment areas through support for NHCs and CHPs; provision of equipment and supplies to health centres for the delivery of IMCI; training in drug use and logistics; supplementation of Vitamin A stocks for children and some provision of essential drugs; and support for creation of community-based plans for HIV/AIDS, including expanded voluntary testing and counseling as well as treatment options, with a focus on assisting mothers or fathers who are or suspect they are HIV positive.

The follow-up Phase III of the MWB Project proposes a major scale-up of activities and coverage to build on work done in the current phase. Scale-up will also comprise the development and integration of IMCI systems within the national health infrastructure contributing to Zambia's being able to meet Millennium Development Goal 4: *To reduce by two-thirds between 1990 and 2015 the probability of children dying between birth and five years of age*. The goal of the proposed next phase is to enhance Zambian development prospects through improved child health survival and its purpose is to develop sustainable health system and community capacity to decrease morbidity and increase the well being of children under the age of five years.

1.2 Evaluation Objectives

The objectives of the assignment were:

- To evaluate the development results (progress towards outputs and outcomes) of the current MWB project (2001-2006).
- To assess the lessons learned (programmatic and operational) from the current MWB project.

- To analyze the appropriateness of the methodology and design of the current project and to advise on how these can be improved in future phases.
- To assess the sustainability of the MWB project (i.e. the phase-out and exit strategies) and how this can be improved to ensure transfer of systems and tools to the MoH, the beneficiary communities and their health authorities.
- To analyze how the project can more effectively respond to the underlying causes of childhood illnesses by strengthening Zambian health sector delivery and management capacity in future phases.
- To assess the overall operational capacity CARE in managing this project and identify any operational improvements needed.
- Based on lessons learned from the current MWB project, to provide CIDA with advice on the CARE proposal for a follow-up phase, including the relevance of the methodology, the capacity of CARE to manage scale-up for the next phase, the appropriateness of the proposal elements involving sustainability and capacity building of the MoH and the appropriateness of the phase-out strategy.

The evaluation Terms of Reference are provided in Appendix I.

1.3 Organization of the Evaluation Report

Section 2 of the report provides an overview of the evaluation methodology. Section 3 presents findings on the internal and external project contexts, while Section 4 summarizes project results and performance on an outcome-by-outcome basis. Section 5 provides lessons, conclusions and recommendations. Appendix I presents the evaluation TORs, while Appendix II provides the detailed evaluation framework used for data collection. Appendices III, IV and V provide the evaluation schedule, list of participants and list of documents respectively. Appendix VI contains the detailed feedback provided by the evaluators on the first draft proposal for the next phase of MWB presented to CIDA in November 2005.

2. Evaluation Methodology

The following section describes the evaluation team, evaluation strategy, framework and tools for carrying out this assignment.

2.1 Evaluation Team

The review was conducted by a team of two consultants:

- Ms. Anne Gillies (Canadian Independent Consultant), Team Leader and Evaluation Specialist
- Dr. Christine Kaseba (Zambian Independent Consultant), Health Specialist

The Team Leader designed the evaluation workplan and methodology, and worked with the Health Specialist (contracted separately by the CIDA PSU in Zambia) to conduct field research. The evaluation report was then prepared by the Team Leader with input from the Health Specialist, CARE and CIDA.

2.2 Evaluation Components

The evaluation was organized into four components as shown in Exhibit 5.1. The evaluation report is organized according to these main components. The major review questions and sub-questions are summarized in a detailed framework in Appendix II.

Exhibit 2.1 MWB Evaluation Components

REVIEW AREA	STRATEGY FOR INFORMATION COLLECTION AND ANALYSIS
Context	Review of the factors (threats and opportunities) in the external and internal contexts that influence current project design, implementation and results, as well as design of the next phase: • External Context: Factors in the broader socio-economic, political and institutional environment. • Internal Context: Key management and organizational factors.
Results Achievement	Review and assess progress towards planned results (outputs and outcomes), in terms of both qualitative and quantitative change. Review and assess sustainability of results, including feasibility of exit or hand-over strategies with partners. Review and assess the degree to which planned results are relevant to beneficiary needs, able to be maintained and built upon in the longer-term team and represent good value for money (cost-efficiency) from the partner and donor perspective.
Key Success Factors	Review and assess the overall efficiency and effectiveness of project management strategies, in terms of their ability to support results achievement. Partnership, appropriateness of design and resource utilization, and informed and timely action will be examined through an assessment of management activities.
Recommendations, Lessons Learned and Design Considerations	Identify the extent to which on-going programming lessons and recommendations and from continuous performance analysis have been incorporated into the current project design and implementation. Identify key lessons (both developmental and operational), and make concrete and constructive recommendations regarding the improvement or enhancement of developmental and operational performance of the current project. Identify concrete recommendations for design of the next phase including the project can help the GRZ to address the causes of childhood illness and provide a strong capacity building contribution to the health sector in Zambia (based on strategic objectives of the GRZ).

2.3 Evaluation Activities

An outline of key evaluation activities and the field mission schedule is provided in Appendix III.

2.4 Data Sources

There were two major sources of data for this evaluation as indicated below.

2.4.1 Individual Participants

The evaluation collected information from approximately 75 individuals in Canada and Zambia. See Appendix IV for a detailed list of participants.

2.4.2 Documentation

Appendix V provides a list of documents that were consulted in the evaluation.

2.5 Sampling of Districts and Project Sites

The evaluation team collected first-hand information on community and clinic level activities and results in three districts where the project has been active: Lusaka, Ndola and Kasama. Out of a total of 47 clinics/health centres and attached community or neighbourhood sites across the three districts where the project has been active, a total of seven clinics were visited (a sample size of roughly 15%) – three in Kasama District, two in Ndola District and two in Lusaka District.

The site visit strategy was tailored to the specific needs and situation of each community, however the following general approach was used:

- Both members of the evaluation team participated in all site visits.
- Each site visit lasted approximately 1.5 to 2 hours, and involved a combination of observations, group discussions and one-on-one interviews with a cross-section of participants, both at the clinic and community levels.
- In all cases except Lusaka, DHMT staff members accompanied the evaluators on the site visits. Seperate meetings were also arranged with the DHMT contacts either prior to or after the site visits.
- A short briefing session was held prior to starting the site visits with local CARE project staff and the DHMT representatives. Following the district visit, a short debriefing meeting was held with CARE staff members and the DHMT representatives.
- In Northern Province, a short visit was paid to one proposed expansion site for the next phase (Mungwi District).

2.6 Limitations

The following limitations apply to the evaluation:

- The Zambian health sector context is very complex and multi-faceted, as well as rapidly evolving. The evaluation did not allow sufficient time to fully investigate and document the context, however it is assumed that CIDA and CARE already both have extensive analytical knowledge of the project's environment.
- Due to time limitations, travel distances and the fact that the mission took place during the rainy season, the site visits for Kasama District were limited to easily accessible clinics. Nonetheless, several different clinics were visited to obtain a good overview and a more accurate picture of the factors affecting them.
- It was not possible to visit 'graduated' sites because no sites were completely phased out during the project as originally planned. Instead, visits were paid to sites where some efforts had been made to scale back direct support by CARE.
- There appeared to be some bias in terms of CARE's selection process for clinics to be visited towards relatively 'high performing' or notably successful sites, especially in Lusaka District. Therefore, information obtained from these visits was balanced against the issues and challenges identified in lower-performing clinics seen in other areas.

Efforts were made to account for these limitations through ensuring that a full range of viewpoints and perspectives were covered during the evaluation, and through qualifying the recommendations as required.

3. Project Context

The following section provides an overview of the external and internal project contexts, in order to situate the project and its performance in relation to major political, social, economic, institutional, donor and programming trends.

> What are the key factors in the external and internal contexts (political, socio-economic and institutional) that have and will continue to influence project design, implementation and results?
>
> What are the key internal factors that have influenced the project's main implementing partners (e.g. CIDA, CARE Canada, CARE Zambia, and the GRZ)?

3.1 Zambian Context

Finding 1: The Zambian health sector has been in 'crisis mode' for several years, creating a challenging environment for service delivery and programming. However, child health is a country priority and opportunities do exist for further improvements in this area.

It is outside the scope of this evaluation to provide in-depth analysis of the evolving Zambian context for child health, which is well documented in a number of key documents and frameworks prepared by the GRZ and the international community including CIDA. However, it is important to highlight the following contextual factors that have dominated Zambia in recent years and influenced efforts to improve health sector performance and service delivery through projects such as MWB:

- Under the HIPC Initiative of the World Bank and IMF, Zambia struggled to meet key targets since 2000 in order to qualify for debt forgiveness and new lending. Public sector investment was slashed, including funding for the health sector. The HIPC completion point was finally reached in April 2005 and as a result the lead creditors have written off 100% of the country's debt, leading to hopes that increased funds become available to meet urgent social needs.
- Even though some key indicators show that the overall economy is improving, over 70% of Zambians live below the poverty line and are unable to access basic services including health care. Poverty levels are still very high with 46% of the population living in extreme poverty and rural poverty rates at 72%. There are signs that unemployment is declining but unfortunately the country's economic expansion is still not robust enough to result in higher employment levels. Women and other vulnerable groups including those living in rural or remote areas have been particularly affected by declining living standards and poor access to health and social services.
- Drought has been widespread in Southern Africa for several years, leading to inadequate subsistence food production and rising food shortages and malnutrition for rural residents. Rainfall for 2005 and 2006 appears to be better, which may lead to increased food production.

> "Over the years, the Zambian economy has been operating in a tenuous macroeconomic environment characterized by inadequate growth and high levels of indebtedness. With inflation too remaining persistently at fairly high levels with single-digit targets appearing like a mirage, the overall quantum of real resources required to meet development needs continues to face serious constraints. The health sector cannot but be afflicted by such a situation." From Health Care Financing in Zambia: A Study of the Possible Policy Options for Implementation (University of Zambia, Ministry of Health, Central Board of Health and WHO, June 2005, page 17)

- HIV?AIDS has had major effects on the overall socio-economic development of the country, through reduced productivity and the increased burden on the health care and social sectors. Approximately 16% of Zambians are HIV positive. The government and donor community are collaborating strongly to provide more funds for the country's HIV/AIDS response, including improved access to ARTs. However, some observers state that the strong infusion of funds in this area (particularly from the Global Fund and PEPFAR) has skewed the attention of the government away from strengthening basic health sector programming towards

provision of HIV-specific initiatives. As well, management of external resources for HIV/AIDS has placed excessive demands on government and possibly weakened their ability to manage other areas of programming.

- Due to many of the above factors, there is a severe shortage of skilled human resources in the public sector as a whole and in the health sector in particular. It is estimated that roughly 50% of government staff positions in health are currently vacant. Pay, working conditions and the levels of morale and motivation are extremely low. The GRZ recently introduced an HRD plan for the health sector that sets out strategies and options for 2006-2011 to tackle the human resources crisis in the health sector.
- Public sector reform initiatives have been very challenging to implement effectively, with many institutional weaknesses and poor motivation to transform old-style governance and management systems. Even though the health sector implemented a decentralization program with its health reform package more than a decade ago, it must now re-align its structures and decision-making processes to fit within an updated decentralization program (National Decentralization Policy introduced within the last two years).

Given all the above factors, the Zambian health sector has obviously presented a very challenging programming environment for projects like MWB that have focused on addressing the pressing needs of a specific segment of the population. Key poverty and health indicators have deteriorated even as the government and donors moved ahead with ambitious plans for further reform and investment. The government has been caught in a vicious cycle of trying to simultaneously reform government fiscal and management processes, meet the HIPC targets, respond to the rising poverty crisis and foster economic growth. Zambia is viewed, nonetheless, as having demonstrated sufficient commitment macro-economic reform and as facing enough important social challenges to deserve further support from the international community.

> "Observers have argued that the health reforms were initially greeted with enthusiasm, and observations of some positive changes were made in the early years of the reform implementation. For instance decentralization led to improvements in resource use, stocking of essential drugs and raising of staff morale. In recent years, however, there has been a reversal of the situation causing a waning of interest in the health reforms and the emergence of some amount of skepticism. This has opened the door to an intense (and on-going) debate about the ability of the reforms to foster better coverage, quality, cost-effectiveness, efficiency, equity and ease of access in basic health care provision." From Health Care Financing in Zambia: A Study of the Possible Policy Options for Implementation (University of Zambia, Ministry of Health, Central Board of Health and WHO, June 2005, page 11)

The Zambian health sector had relatively ambitious programming and policy reform framework since the early 1990s, many of which were supported generously by international donors and provided a relatively strong enabling context for further programming investments in health (see Section 3.2 below). However, the level of government political and financial commitment to the previous National Health Strategic Plan (2000-2005) was weaker than expected and the current budget allocation to health is still quite low at 10.7% of the total budget. The fourth NHSP (2006-2011) lays out a strategy for improving management, coordination, service delivery and effectiveness of the health sector through on-going decentralization. This may prove to be a challenging task especially with the recent dissolution of the Central Board of Health and functional health boards that were set up to facilitate decentralization of power, which may have deleterious effects on institutional arrangements in the health sector. However, the overall aim of the new NHSSP is to create a stronger budgetary framework for health investment as well as setting stronger

priorities, but is still unclear what level of financial commitment will be offered by the government to back up its ambitious plans for reform and service delivery.[1]

Starting in 1996, the GRZ adopted IMCI (an approach endorsed and promoted by WHO and UNICEF) to respond to child health issues[2], and in the early 2000s indicated that it would strive to achieve MDG#4 using IMCI as one of the key strategies. By 2003, roughly 50% of districts in Zambian were implementing some form of IMCI, mostly health worker training for case management. However, there remain many on-going problems with quality assurance and continuity/scope of coverage. For example, remote and rural districts have less IMCI coverage. High turnover of health workers means that the training process (which is quite costly) has to be nearly continuous.

Summary of key Zambian health sector studies, plans, frameworks and policies that relate to child health and IMCI

National Health Strategic Plan 2006-2011: Presents increased focus on IMCI, specific targets and indicators set for national expansion and roll-out to all 72 districts (from current 38 districts).

Child Health Policy 2006: Still under development. Analyzes key issues and approaches, and presents comprehensive IMCI as a key strategy to reduce the disease burden in children and meet MDG #4. The policy also has a draft implementation and monitoring plan for the objectives.

Child Health Situation in Zambia 2005: Situational analysis produced by MOH as basis for the new Child Health Policy, which contains important historical information on evolution of IMCI strategies over past several years in Zambia. Documents key causes of childhood illness and the gradual growth and improvement in child health practices at the community and district levels.

National Strategic Plan for Child Health in the Community (Community IMCI) 2005-2009: Proposes an operational framework for community IMCI implementation, with implementation steps to be applied from the national to community levels.

IMCI Orientation and Planning Guidelines for Provinces and Districts 2005: Intended to support implementation of the C-IMCI NSP through more detailed information on how provinces and districts can proceed.

IMCI National Strategy 2004-2006: Provides useful contextual information on IMCI in the national health structure, as well as SWOT analysis and costed plans. Coverage targets set are unlikely to be achieved.

IMCI National Health Facility Survey 2001: Survey demonstrated an improvement in case management practices by health workers who had been previously trained in IMCI.

In recent years, there was intensified policy and planning support for child health and IMCI in Zambia (see sidebar). However, translation of these policies into feasible and budgeted action plans, especially at the district level, has been and remains a challenge. As well, the proliferation of the many frameworks and plans related to child health has presented some institutional coordination challenges at different levels. The institutional management structure for IMCI appears to be somewhat confused, with responsibilities divided between the UCI Secretariat of the Ministry of Health and the Directorate of Public Health and Research at the Central Board of Health. The dissolution of the CBOH has also created confusion about roles, responsibilities and institutional accountability structures that may take some time to resolve.

The original design for the current MWB project was evidently based on the assumption that sufficient resources would be available for the GRZ to continue to support and possibly scale up IMCI in a significant way in the early 2000s. In practice, the government has not been able to commit enough

[1] The national budget released in February 2006 (while this report was being prepared) may provide a clearer indication of the level of investment likely to occur in child health for the coming year at least. Primary and community health care received a special mention in the budget and the government allocated K1,098 billion to cater for community initiatives in addition to HIV/AIDS control and mitigation, medical equipment and drugs. This money will also be spent to recruit 800 medical personnel to address human resource shortages in health institutions.

[2] IMCI has three inter-related components: 1) health worker skills development; 2) strengthening of health systems; and 3) improvement of community health practices and behaviours (so-called 'community IMCI'). Implementation of all three components simultaneously is often referred to as 'comprehensive IMCI'.

resources due to many urgent demands and competing priorities The role of the District Health Management Teams is particularly crucial, as within the decentralized MoH structure these bodies are supposed to be fully responsible for planning, budgeting and implementation of service delivery. Donor basket funds for the health sector have been in place to support district activities (including some funds earmarked for child health activities), but it appears that the many systemic institutional capacity weaknesses at the district level have resulted in poor allocation and utilization of these funds. As will be described later in the evaluation report, many of these factors have had a considerable affect on the achievements of the MWB project and will likely continue to influence any future phase.

Causes of and Responses to Under-5 Health Issues

The document *Child Health Situation in Zambia* published by GRZ in 2005 provides the most recent comprehensive overview of underlying causes of child health and the strategies being used to address these issues. Rather than repeat the essential information contained there, readers are referred to this key document for further background. Zambia is among the 42 countries in Africa contributing to the 90% of all under-5 year deaths in the world. One in six Zambian children die before their fifth birthday. Around 17-19% of deaths are attributable to diarrhea and pneumonia while 28% are due to malaria. Approximately 47% of under-5 children in Zambia are stunted. Wasting levels are highest for the ages six to 23 months, the period during which the child is weaned and consequently is more vulnerable to illness (basic statistics are extracted from the Zambia Demographic Health Survey 2001/2002).

The Zambian National Population Policy (1990) targeted the reduction of infant mortality from 97 deaths per 1,000 live births in 1980 to 65 per 1000 live births by the year 2000 and to 50 per 1000 by the year 2015.

By 2001, an infant mortality rate of 95 deaths per 1000 live births was achieved, well below the original target. Therefore, it would appear to be unrealistic to expect an achievement of the target of 50 deaths per 1000 live births by the year 2015 according to the 1990 policy. However, the MDG-related target of reducing the IMR to 65 deaths per 1000 may be achievable with sufficient investment and technical support to increase quality and scope of IMCI coverage as well as quality of institutional management systems needed to sustain service delivery over time.

On the positive side, it is encouraging that child health and IMCI are recognized as priority areas by the GRZ. The MWB project has benefited from this prioritization, and at the same time it has definitely helped to foster stronger government attention to child health through demonstrating that measurable benefits are possible from IMCI programming even under challenging conditions. It appears that the government may be poised to make more investments in child health in the immediate future. However, such factors as the elimination of some user fees for health services (even though this is a laudable effort in improving service access for the poorest of the poor) will limit local resources at the same time that demand for services grows. Strategic opportunities do appear to be emerging for IMCI, however the challenge will be to ensure that new initiatives are properly positioned to have the most sustainable effects within the rapidly evolving, complex and risk-prone national context.

3.2 Donor Context

Finding 2: There has been strong donor coordination around support for the Zambian health sector. Donors have invested considerable amounts in health-related PBAs, but it appears that earmarked resources for child health have been lower than required.

The international donor community has worked closely with the GRZ since the 1990s to establish strong program support mechanisms for the health sector. Key donors for health sector SWAPs so far include DFID, the Nordic countries and USAID. CIDA has not contributed directly to PBAs up to now, but it has provided important assistance in strengthening health sector capacities through targeted project investments in alignment with the overall sector support strategy (see Section 3.3. below). The donor Cooperating Partners (or CPs) for the health sector meet monthly to discuss strategies among themselves and then meet regularly with the MoH. Various joint donor/government sub-committees also meet regularly to cover key thematic areas. As a result, there is a very mature SWAP environment, and donor harmonization and alignment around health sector support appears to be quite strong.

Canada joined other donors in signing a Harmonization Framework in April 2004. The implementation of this framework promoted ownership, alignment, and harmonization through actions such as increased use of direct budget support, establishment of more SWAps, increased reliance on government systems for procurement, fund management and auditing, use of Technical Assistance pools and eventual preparation of a Joint Assistance Strategy with clearly demarcated division of labour. The government is now preparing a comprehensive National Development Plan that will guide government priorities and donor interventions. It is expected that the draft NDP will be presented to donors in mid-2006 and that donors and government will convene shortly after that to discuss the Joint Assistance Strategy as the framework for international cooperation and on-going development investment in all areas including health.

The CPs invested in district basket funds for health over the past several years that were primarily dedicated to delivery and expansion of decentralized health services. Over time, donors allowed the district basket funds to be used to cover salaries and drug procurement as well as direct programming costs. The main challenge has been ensuring that districts have management capacity to allocate the basket funds wisely and account accurately for their use. Some concerns have been raised by the donors that the funds were not always used by the districts on priority areas such as child health due to lack of expertise in managing competing priorities. In other instances, where extra funds were allocated by the GRZ to child health in 2004 and 2005, donors and the MOH evidently decided to put the bulk of funds towards increased EPI coverage because of lack of clear evidence that further investments in broader child health programming (including IMCI) would be well-used by districts. All CPs appear to be very concerned about district accountability for appropriate use of basket funds, but there does not appear to be any clear strategy for how to work with government to address these concerns. The recent revival of Provincial Health Offices may provide increased guidance to districts in effective use of child health resources, but the PHOs often lack technical depth as well.

Many agencies and donors continued to provide project-based funding and/or technical advisors at the same time as investing in basket funds. For example, JICA, UNICEF and USAID all invested at different times in TA or project support for IMCI (mainly health worker training or funding for district or provincial clinical specialists in child health). These initiatives complemented the MWB project in the three districts where it worked, and CARE cooperated well with other agencies at the level of implementation. Key donors also participate at the national level in groups such as the Interagency Committee on Children (IACC) and the IMCI Working Group (which CARE was also invited to attend due to its involvement in IMCI via the MWB project). However, several donors and the MOH itself have state that the functioning of the IMCI Working Group has been weak, in terms of ensuring that sufficient resources in the district basket funds were earmarked to child health and to sustaining IMCI activities. As well, neither CARE nor CIDA have participated regularly or at all in some of the more powerful committees and working groups in which key policy and budgeting decisions were made related to allocation of resources to child health.

Currently, several lead donors including DFID are beginning to increase their commitment to general budgetary support, partly due to a perception that the health sector is over-subscribed. In time, this could well lead to a decline in resources available for district funding in the health sector as there is as yet no guarantee that the Ministry of Finance will be able to maintain adequate health funding levels. On the other hand, many donors also cite the government's new strategy for Human Resource Development in the health sector as being very encouraging as it will address cross-cutting issues related to service delivery that will also positively affect decentralized health efforts such as IMCI.

In summary, it appears that the donor context was quite enabling over the project's lifetime but that some key opportunities were missed by CIDA at the central level to leverage further investment in child health, and to ensure that sufficient funds were available for district use in order to take over IMCI leadership. Since 2001, a great deal of donor attention was focused on the health sector, the basket funds were available (in theory at least) to help districts implement key health activities, and CARE engaged in useful interagency and government cooperation for ground-level implementation. However, it would have been

very useful to ensure that lead donors in the health sector obtained more information about the success of community IMCI strategies (as demonstrated through the MWB project) as well as the necessity of increasing district resources specifically earmarked for IMCI. In addition, it could have been useful for the CPs and government to discuss in more detail what type of concrete institutional capacity building was needed for districts in order to ensure they could adequately plan, budget and account for child health funds, based on what was discovered through the MWB project. It will be important in any future phase to analyze how to create the central policy and donor leverage opportunities required to complement project-level investments of this type. This is obviously not CARE's sole responsibility and the main thrust at the policy level must come from CIDA as a CP in the health sector.

3.3 CIDA Context

Finding 3: CIDA's involvement in Zambia has evolved considerably over the past several years. Zambia is now considered a priority country in Africa for increased Canadian aid investment, with support for child health identified as a top CIDA priority.

CIDA's country program support for Zambia has undergone some marked fluctuations over recent years but is now expanding again. The previous Country Development Program Framework (CDPF) for 1998-2001 focused mainly on investments in the health and education sectors with program funding set at approximately $6-$7M CDN per year via traditional project-based support. Key projects in the health sector during this time period were mainly in reproductive health and support for community involvement in HIV/AIDS prevention and care. Staffing and analytical support for the country program remained at maintenance levels during this time period. The CDPF was updated internally in 2001 (with an increased focus on Zambia's key position in the regional programming context), but the 2002-2004 period was one of uncertainty with regards to program allocations and long-term strategic planning. However, in early 2005 the Canadian government's new International Policy Statement indicated that Zambia would again became a focus country for Canadian programming in line with Canada's commitment to Africa through the G8 and NEPAD initiatives. Programming began to be readjusted again to position CIDA more effectively in relation to larger budgets and harmonized aid mechanisms.

Currently, CIDA is seeking approval for an Interim Country Strategy for 2006-2008 in order to gradually scale up programming once again. It is expected that over the next three years the country programming budget could gradually increase to around $20M CDN per year, and health sector programming is expected to comprise about 90% of funding commitments, including an increased focus on PBAs. Modalities would include continued support for strengthening government procurement via participation in a drug supply basket fund, investment in the MOH's human resource development strategy as well as a strategic combination of PBA- and project-based support for child health. One of the main challenges has been the need to expand CIDA's analytical capacity, especially in the health sector, to support these expanded programming approaches. A new health sector specialist was hired for the PSU in 2005, with more health specialist staffing planned in 2006-2007 under the Interim Country Strategy. However, one challenging development is that Foreign Affairs recently announced plans to restructure the Canadian presence in Zambia, with the Zambian CHC becoming an office of the High Commission in Harare, Zimbabwe sometime during 2006. It is hoped by many at CIDA that Foreign Affairs may reconsider this decision in the near future due to its implications for effective management of an expanded aid program in Zambia.

CIDA has been cautious in terms of committing funds to health SWAPs in Zambia, even though there is strong support in principle for harmonized sector support. Unlike other donors with deeper pockets, the Agency was reluctant to engage due to on-going fiscal management and accountability weaknesses demonstrated by the GRZ. Instead, CIDA tried to invest strategically in other forms of TA and project-based support to preserve its place at the table within health sector support programs. CIDA carved out a niche in relation to strengthening procurement systems for essential drugs, via funding for the

Pharmaceuticals Project, provision of Canadian procurement specialists and regular participation in donor/government working groups on reform and harmonization of procurement procedures.

The MWB project up to this point appears to have been a strategic way of demonstrating that Canadian aid resources could reach most-at-need beneficiaries in a focused and accountable way. CIDA has been content to play a largely 'hands-off' role during the current phase, and has not actively sought out ways to ensure that broader health sector reform and policy issues were synergistically linked to the project. It has been proposed that Canada could play a niche role in future and specialize in support for under-five health in Zambia in line with the new NHSP. As a result, the Agency will need to decide whether some form of earmarked sector or budgetary support would increase its profile, credibility and opportunities for policy leverage in child health, which would strongly complement project-based funding.

As will be described later in this evaluation report, CIDA's project investments via CARE in IMCI risk being compromised to some extent if MOH partners are not provided with adequate resources from other sources to sustain decentralized, community-based service delivery in child health. As well, the Agency will need to commit sufficient analytical resources towards participation in various multi-donor committees, working groups or task forces around child health at a national level, in order to align more closely with broader donor initiatives and to ensure that CIDA becomes a key player at the child health policy table. Finally, CIDA programming staff and the present Canadian High Commissioner acknowledge that there is a strong need to create better strategic and lateral linkages between the Agency's different health sector investments (procurement, HRD and child health), for example, by transferring what has been learned from project-based IMCI work (which incorporates activities related to health worker incentives and rational drug use) to other programming areas, and vice versa.

3.4 CARE Context

Finding 4: CARE Zambia has developed strong expertise in IMCI implementation, with technical and administrative input from CARE Canada. Both agencies have undergone extensive learning about how to effectively link the community and institutional components of IMCI, based on their experiences with the MWB project.

Both CARE Zambia and CARE Canada have excellent reputations and track records in implementation of community-based health programming. However, prior to the MWB project (starting with a pilot phase in 1999), neither agency had any specific expertise in IMCI. Nonetheless, CARE Zambia was relatively well positioned due to its past programming experience to focus strongly on both the health worker training and community components of IMCI. The C-IMCI component requires strengthening the community's involvement in and demand for integrated child health services, and prior to CARE's engagement little or no work had been done on exploring how to implement this in Zambia. According to some, IMCI did not 'take off' in Zambia until CARE became involved in the community component to demonstrate how it could actually be done, through creating what one evaluation informant referred to as a 'living university' for C-IMCI. Key documents such as the Zambia Child Health Situation Analysis completed by MOH in 2005 indicate that the CARE MWB project has been the largest single initiative in community-based IMCI programming from its launch in the late 1990s up to the present.

CARE Zambia can be viewed as a 'generalist' NGO that sometimes adapts its programming directions depending on the types of resources available from funders, but the agency is currently developing a new country strategic plan that reinforces its on-going commitment to health programming as an important 'cross-cutting' component of most of its community-based development work. The agency's annual budget for development programming averages around $10-$11M USD per year, not counting additional resources received for food aid in recent years. CARE's perspective has been that with the massive influx of HIV/AIDS funds into Zambia in recent years, it was and continues to be absolutely essential to undertake specialized programming in the area of under-5 health. While there were limited resources to hire specialized health sector programming experts in the past, CARE Zambia now has plans to hire a

Health Sector Coordinator in 2006 to provide better in-house technical oversight of its on-going and new health projects. It is interesting to note that for the past several years the MWB project has been one of the smaller bilateral investments managed by CARE Zambia, and that there has been a strong reliance on CARE Canada (even though it is a relatively 'minor' partner compared to other members of CARE International) to provide technical advice from a distance to ensure smooth functioning of MWB.

CARE Zambia's credibility as a lead IMCI implementer and technical resource in child health programming increased exponentially through the project. CARE was called on by MOH to provide technical input on various IMCI and child health committees and task forces, and to provide substantial input on IMCI training design, materials and guidelines. For example, based on the expertise gained via MWB, CARE was instrumental in helping to recommend ways to reduce IMCI training costs through developing effective models for non-residential training, as well as offering technical support to the development of guidelines for provincial and district planning on IMCI. There appears to be strong evidence that CARE Zambia (by virtue of its support for IMCI) has filled an important strategic niche in terms of providing some advice and input on various Zambian government policies in IMCI, as well as ensuring good cooperation among donors in child health. CARE also added considerable value in regards to the training, motivation and deployment of community volunteers and the empowerment of community structures, due to its extensive community development expertise.

However, for understandable reasons it has also been quite challenging for CARE to position itself at the national level in order to have some influence on IMCI policy issues. CARE has been involved in other projects to build Zambian government capacities and CARE Canada also has expertise in governance reform, but it appears that the skills and strategies gained from these initiatives could perhaps have been transferred more effectively to the MWB project. CARE is viewed by many development agencies and by government itself to some extent as a type of 'surrogate service provider' in the area of IMCI. As a community development NGO, it has been so efficient at anticipating and filling needs through a very strong community-based model that it has almost created a parallel IMCI management system to government (at least in the districts where it operates). It is clear that CARE is very comfortable at the grassroots level of community mobilization, training and health service delivery, but perhaps somewhat less skilled and not as credible as an NGO in dealing with the challenges of contributing to central policy issues and/or in building government IMCI management capacities. It is quite obvious that CARE cannot function at the same level as the CPs engaged in health sector policy reform and PBAs, even though it has tried to stay informed about and fully engaged in the rapidly changing health context.

For CARE, there are obviously specific challenges in working exclusively from a traditional NGO 'project perspective' when all health investments need to be carefully related to the bigger picture of sector budget and policy reform. As will be described later in this report, policy influence at the central level is definitely an area where a stronger strategic linkages between CARE and CIDA would have been helpful during the life of the current project, in order to analyze and respond to the broader funding and management issues related to IMCI and find ways to advocate with the CPs and central government for more child health resources to ensure that IMCI can be sustained. While it would certainly not be fair to blame CARE for its lack of central policy influence in the recent past (as that is a difficult role for an NGO to play directly), the current MWB project does highlight the importance of both donors and NGOs finding more effective ways to create effective bridges between different levels of support in the health sector. For future phases, CARE will probably need to shift its programming paradigm slightly as well as mobilize different types of technical expertise than found in the previous MWB project to increase its ability to build government institutional capacity in IMCI. CARE will also need to be engaged in a much stronger strategic alliance with CIDA in order to help leverage central policy and funding support for IMCI. These could be slightly new roles from an NGO perspective that could present some organizational challenges for CARE if not handled carefully.

Other points related to CARE's programming and management capacities as well as accountability relationships between the two CAREs are included in Section 5.2 below.

4. Project Results Achievement

The following section provides an outcome-by-outcome summary of key findings related to results achievement, organized according to the main results found in the project's original LFA and combined with analysis of key supporting outputs as identified in the most recent project reports. For each outcome area, a synthesis is provided of the main achievements and overall progress noting strengths, weaknesses and possible areas to reflect on in design of the next phase. In addition to field research data collected in January 2006, the evaluation team attempted to validate information already provided in reports, surveys and presentations.

> What has been the progress towards planned outputs and outcomes, in terms of both qualitative and quantitative change?
>
> To what degree have the results been relevant to beneficiary needs, sustainable and cost-efficient from the partner and donor perspectives?

4.1 Outcome #1: Caretakers' Knowledge and Practices

Finding 5: The project's strong focus on C-IMCI led to some positive changes in caretaker knowledge and practices in child health. However, it was very hard to measure the extent of these changes accurately and sustaining them may be difficult.

> Outcome #1: Improved caretaker knowledge and practice of health seeking and promotion behaviours.
>
> Supporting Outputs: 1.1 Network of CBOs formed and trained; 1.2 Analysis of caretaker health education needs; 1.3 Available health education capabilities, materials and resources reviewed; 1.4 Health education programs designed; 1.5 Health education programs implemented and continuously assessed.

The MWB project hoped to demonstrate that integrated, community-focused delivery of IMCI in selected districts could have a measurable effect on the knowledge and behaviour of caretakers (mainly mothers) regarding how to protect and improve the health of under-5 children. The main areas for change were identified as

- improved knowledge about how to prevent, manage and treat diarrhoea, malaria and pneumonia,
- improved basic household sanitation practices (handwashing, latrines and water purification), and
- improved rates of participation in community-based Growth Monitoring Points.

The main mechanism for achieving these changes was community-based health education delivered through community groups and volunteers (i.e. NHCs and CHPs), in order to convince caretakers to play a more active and informed role in protecting the health of their children (see analysis of Outcome #2 for more information on the techniques used to build skills and capacities of community volunteers).

In practice, it was quite difficult for the project to achieve and measure this outcome, as caretakers were really secondary beneficiaries who were to be reached in turn by the project's primary beneficiaries (e.g. community volunteers and health workers). As a result, the evaluation team found that it had been challenging for the project to analyze its effects on caretakers in a meaningful and accurate way.

Nonetheless, project survey data and anecdotal qualitative information collected by the evaluators could be interpreted to show some positive indirect effects in this area. The project attempted to directly measure caretaker changes over time through annual household surveys (based on randomized sampling) in areas where the project worked. However, different variations of the indicators were used for data measurement from year to year, so it was very challenging to deduce clear and consistent change patterns from the available baseline and survey data in all the specific areas targeted for caretaker change. Also, it appears that the sample group kept changing over time. These slight confusions and inconsistencies were

reflected in the results data provided in project reports, but the data quality was not adequately explained or analyzed to account for variations. In most of the key areas measured for caretaker change via the household surveys (see sidebar), some improvements were measured but it was difficult to understand the significance of the changes in relation to the broader target group, given the relatively small sample used (n=252). As well, no comparative data was collected to demonstrate any key variations in caretaker knowledge and behaviour between project and non-project communities.

Key areas measured for caretaker knowledge/practice via annual household surveys (NOTE: not all indicators were used consistently during the life of the project)

Ability to manage diarrhea and knowledge of correct procedures for preparing and administering ORS

Ability to identify signs of pneumonia

Participation in Growth Monitoring Points

Ownership and utilization of Insecticide Treated Bed Nets

Ability to identify methods for making drinking water safe

Ability to identify methods for improving toilet sanitation and handwashing

Ability to identify correct methods for HIV/AIDS transmission

The project was quite effective in terms of the techniques it used to promote community health education and mobilization strategies within the health system, and in trying to ensure that the individual caretakers were better informed and engaged by individual health workers and volunteers. Several CHPs interviewed by the evaluators stated that there was increased receptivity among community members to health education and behaviour change messages from community volunteers, whereas there is often some resistance to information or advice offered by health workers. Information collected from a small number of caretakers interviewed by the evaluation team at the community level (mainly at several Growth Monitoring Points visited) suggested that they were enthusiastic about participating and relatively well informed about some child health topics. However, in one community visited (where CHP outreach and growth monitoring had been conducted for at least three years), the evaluation team conducted several short, unannounced visits to a number of households and found very poor 'off-the-cuff' knowledge about several key health and sanitation issues used as project indicators (e.g. knowledge/use of bed nets and handwashing). This could indicate several things, for example, that caretaker behaviour change was a much more complex process to manage and measure than the project survey data showed and that it required considerably more time and energy than anticipated to create sustained or significant change at this level.

Given these challenges in properly defining and measuring these changes, future phases will need to determine how realistic or feasible it may be for the project to aim for and measure any direct effects among caretakers. There is no doubt that caretaker behaviour can be an important proxy measure for the health system's effectiveness in conveying key health promotion messages (either via health workers or community volunteers), but whether it should be a separate outcome is debatable. In fact, change in caretaker knowledge is probably more like an impact. As part of building institutional capacity to sustain IMCI, it would obviously be essential to continue to strengthen clinics' and districts' own capacity to improve caretakers' knowledge and behaviour through public health approaches, as well as how to in simple but accurate ways whether they are having an effect this level.

4.2 Outcome #2: Improved Child Health Service Delivery

Finding 6: There is good evidence that IMCI case management by individual health workers was strengthened a great deal by the project, as well as knowledge and skills of community-based volunteers. Issues remain with how to ensure further replication and quality assurance of IMCI services by clinics and communities.

> Outcome #2: Improved delivery of health services by clinicians, CHPs, NHCs and THs
>
> Supporting Outputs: 2.1 Partners mobilized to select and support community volunteers; 2.2 Community volunteers trained; 2.3 Clinicians/health workers trained; 2.4 Desired ratio of community volunteers achieved; 2.5 Community volunteers able to sustain health services without project support; 2.6 Child health programs integrated into on-going community programs; 2.7 On-going training and supervision; 2.8 Improvements in quality of care

The project invested the majority of its resources and development efforts on achievement of Outcome #2, which was centred mainly on training and capacity building of individual health workers and community volunteers. Based on the project's own performance measurement as well as information collected by the evaluation team, it appears that IMCI case management practices by health workers improved considerably over the life of the project, mainly due to training, technical supervision and coaching provided either directly by the project and/or through districts (see, for example, Table 15a, page 24 in the Moyo Wa Bano Project Survey, 2003). As a consequence, it appears that the range, quality and scope of IMCI service delivery within project sites improved, compared to non-project sites with less intensive external support. Measurement of improvements in case management was done through the annual project survey via a randomized observation checklist applied with a small sample of selected health workers. For understandable reasons, it was much harder for the project to measure changes in knowledge, skills and practices of community-based volunteers, so various proxy indicators and qualitative assessments (including changes in caretaker knowledge under Outcome #1) were used instead.

There was strong technical expertise among project staff (all former frontline health workers themselves) regarding methods for training health workers in IMCI, for improving service delivery by health workers, and for mobilization of community-based support for clinic services. As mentioned in the context section of the report, the project made contributions to improving cost-effectiveness of IMCI training approaches by demonstrating that non-residential training could be as effective in imparting core competencies as residential training. At the same time, it was relatively easy for the project to work with health workers as they were highly motivated to participate in any professional development courses. The IMCI training was practical, experiential and hands-on, so it provided interesting exposure to new training techniques for health workers. The project focused on a broad-based training approach to create a critical mass of IMCI specialists within each clinic, and also increased its focus on training-of-trainers over time to create strong groups of qualified trainers within each of the three targeted districts. These training approaches all appeared to be methodologically and technically sound and evidently yielded positive effects in terms of consistency and quality of IMCI services, from what the evaluation team could determine. However, one of the on-going challenges that emerged was the fact that IMCI training had to be budgeted for and offered/reoffered nearly continuously by the project to account for health worker turnover and attrition.

The evaluation team interviewed a number of health workers and their supervisors trained in IMCI by the project (including clinic in-charges, nurses and nursing aides). They were unanimous in praising the training they received as well as indicating that it had led to rapid improvements in their ability to respond more systematically and professionally to urgent child health needs. In several instances, the evaluators were able to directly observe intake practices in the clinics visited, and noted high levels of confidence, empathy and thoroughness among health workers trained in IMCI. It is worth noting that for most clinic-

level health workers trained in a traditional nursing model, this was the first time they were provided with practical, empowering tools for use in frontline disease screening and intervention.

For community-based volunteers, it appears that the project also provided high quality training. Training in health prevention offered to CHPs and NHC members was intensive and based on participatory adult learning models. A small sample of CHPs, NHC chairs and THs interviewed by the evaluation team attested strongly to the sense of empowerment and agency they gained via the training obtained from the project. At the Growth Monitoring Points visited by the evaluation team, CHPs were observed doing a variety of basic health promotion and referral activities conscientiously and well. The project appears to have been particularly effective in creating functional relationships with THs at the community level, and in breaking down some of the distrust or suspicion felt by health workers towards this group. The CHPs interviewed expressed a strong sense of themselves as integral to the health system, and the evaluators saw many examples of strong mutual respect between the clinic workers and CHPs. Again and again, health workers cited the role of community volunteers as important for helping to reduce clinic congestion and health worker overload. The CHPs were also extremely proud of having created many new GMPs in order to increase community access to health promotion service, although they did note that there was a need for greater access to nutritional supplements or other resources in order to ensure that challenges in maintaining growth for under-5 children due to household poverty could be addressed.

Key role of Growth Monitoring Points as the basis for community IMCI

The project paid considerable attention to helping community volunteers and health workers devise ways of expanding and supporting GMPs as the key community nexus for promotion of child health. GMPs have been in place in the Zambian health system for some years but in many communities were underutilized and under-resourced, so had fallen into disuse. The project encouraged NHCs and CHPs to focus their activities around holding regular GMPs, and provided basis equipment such as educational materials, weighing scales and pens and papers for recording growth information. In other instances, small amounts of money were provided to help residents build permanent roofs or walls for the shelters. Clinics were encouraged to designate community IMCI FPs who attended GMPs on a regular basis to provide vaccinations or to back up screening and referrals by the CHPs. There is strong evidence that this strategy of revitalizing and expanding GMP coverage by the project provided very good concrete support for IMCI, but also that the volunteers running the GMPs require on-going support, supervision and mentoring (from either CARE or the clinics) in order to continue their work.

Issues and challenges related to community volunteer incentives

Common to many development projects and programs dependent for success on high levels of participation by community volunteers, the MWB project experienced challenges in deciding how best to provide incentives to CHPs. CARE Zambia's policy has always been not to provide monetary incentives, but an increasing number of donor agencies and NGOs do. Especially in urban areas, lack of incentives appeared to lead to relatively high rates of attrition among CHPs trained by the project. For example, in some clinics visited by the evaluation team, up to 30% of trained IMCI volunteers were no longer active. While this may not necessarily be attributed to lack of cash incentives, nearly all volunteers interviewed highlighted the issue as crucial for their continued involvement in community-based IMCI work.

The MWB project experimented with the idea of introducing and providing seed funds for small-scale Income Generating Activities (IGAs). Initially, the evaluation team was highly skeptical as it was assumed that the IGAs 1) risked deflecting resources and energy from core project activities; and 2) were not sustainable in the long term. On closer examination, the IGAs appeared to have some justification and provided increased motivation for a limited number of community volunteers. Nonetheless, it would be very useful in future for the project to take a much broader and critical view of issues related to incentives for community volunteers, by helping the Zambian health sector examine the role of community health volunteers and assess how best to support them in the long-term. One of the key challenges faced by the health sector is how to manage its dependency on volunteers without exploiting them or taking them for granted. This is particularly important as the vast majority of community volunteers are women. Projects such as MWB may be able to assist the Zambian government in analyzing the policy and budgetary implications and options for remuneration and sustainability of this fundamental but largely 'invisible' cadre in the health sector.

For comparative purposes, the evaluation team were able to visit a couple of clinics where both health workers and community volunteers were trained in IMCI screening and case management, but outside the MWB project. These sites were still connected to the project in the sense that project staff members were still involved to a lesser extent in supporting and reinforcing district outreach and supervision. In these cases, some key differences were observed in terms of the knowledge, motivation and engagement exhibited by both groups, as compared to 'core' MWB project sites where more intensive work had been done. The depth of training offered to community volunteers was reduced in non-project sites in order to save costs, and as a consequence the knowledge base and motivation of CHPs appeared to be somewhat lower.

Given that pay is low and working conditions are extremely tough for Zambian health workers, training is viewed as a way of gaining additional knowledge and expertise, especially in relation to promotions and new and higher-paying jobs. Unfortunately, these factors also undermined the effectiveness of some IMCI training efforts as workers changed roles or sought to be promoted at the first opportunity after receiving training. The project attempted to deal with this either through saturation of training at the clinic level and/or by negotiating with districts to minimize staff rotations. It appears that these efforts were only moderately successful, given the realities of the health system. In other cases, the project found that motivation of health workers who were serving as community focal points for IMCI was negatively affected by the fact that they were not provided with incentives such as meal allowances for doing outreach activities that in theory should have been part of their core job descriptions. Both these issues would likely need to be addressed more rigorously in future phases.

Health workers and community volunteers also received training in community level data collection and analysis, and health workers received training in rational drug use to reinforce clinic procurement systems. Both these specialized aspects of training for the two key target groups will be discussed in subsequent sections, as they link closely to issues related to health system management of IMCI (Outcome #3).

However, one of the main observations by the evaluation team was that project staff were generally perceived by both clinic workers and the community as the 'go-to' people for IMCI problem-solving, in spite of efforts made to shift quality assurance and follow-up activities to the districts (see below under discussion of Outcome #3). Clinics and CHPs relied heavily on the project to provide basic equipment, materials and drugs that were still difficult to obtain through regular health channels. As will be discussed below, this appeared to create some challenges for how to ensure effective hand-over of full IMCI management responsibility to the clinics and districts, due to the fact that the both health workers and community volunteers identified IMCI training and resources primarily with the CARE project rather than with the government health system.

In summary, while there was nothing wrong with the fact that *individual* health worker and volunteer training and support appears to be where most project expertise and attention was

Rationalizing and analyzing the long-term role of community-based health volunteers including CHPs

The MWB project recruited and trained nearly 4,000 CHPs to support the community component of IMCI. The project was relatively successful in achieving a ratio of approximately 50 households to one CHP in order to ensure adequate community coverage and to reduce volunteer burn-out. The theory behind creating such a large number of CHPs was sound, and in practice it allowed the project to increase and intensify IMCI service delivery and referrals in the target districts. However, there appear to be several issues related to this approach that deserve much closer analysis in future. One is the ability of the MOH as a whole to replicate and sustain the CHP-based IMCI model, given that it requires a lot of expertise and interest in fostering community-based volunteerism that may not already exist in the health system. Another is the extent of overlap between CHPS and existing CHWs, and the pros and cons of combining the two cadres for community-based IMCI support in the long term so as to avoid a proliferation of community volunteers with overlapping agendas and possibly competing spheres of influence. Finally, the implications of focusing efforts on community-based volunteers may need to be considered in relation to the government's new HRD strategy for the health sector.

focused, it may have inadvertently skewed the project away from more challenging but equally important areas including how to effectively to support and reinforce institutional change in the health sector related to IMCI. One of the main challenges for a future phase (which is acknowledged as important by the CARE staff) will be to move from the individualized, site-specific focus in IMCI towards a more comprehensive institutional approach, in order to ensure that individual learning about IMCI can be transformed into long-term, systemic change.

4.3 Outcome #3: Sustained IMCI Management

Finding 7: While strong linkages were established with the three districts (as well as with targeted clinics), the project had difficulties in transferring full 'ownership' of IMCI to district partners and in strengthening long-term IMCI management systems at this level.

> Outcome #3: Sustained IMCI management by DHMTs and clinics
>
> Support Outputs: 3.1 Service providers trained in rational drug use and better drug procurement; 3.2 Clinic HMIS reporting strengthened; 3.3 Child health promotion activities integrated into regular clinic activities; 3.4 Hand-over strategies developed and met within specified timeframe.

The project hoped to ensure that both clinics and DHMTs were equipped to take over long-term management of IMCI, particularly those related to the community component. The key mechanism for doing this was to work with clinic and district supervisory staff in order to improve oversight, monitoring and drug procurement systems that would then form part of on-going IMCI management structures. Project inputs included a mix of training (including skills development in IMCI supervision, HMIS and rational drug management), mentoring through field visits and continuous meetings/discussions with key managers and staff members. Clinics were encouraged to build IMCI into their day-to-day practices by creating specialized screening rooms, for example, and by better organizing client intake practices for mothers and children.

At a basic level, it appears that all these inputs were well-organized and had positive short-term effects on the motivation and performance of individual health workers, FPs and supervisors. There is strong evidence that the project did strengthen the district's IMCI FP position and skills as well as catalyze more district attention to IMCI. In particular, health workers and district health officers cited rational drug use training as having been very effective in reducing drug stock-outs. This is borne out by the project's own monitoring of IMCI drug availability and procurement, which appeared to improve in project-supported sites over time. On another level, the project was evidently less successful in producing medium-term systemic change and in strategically reinforcing the districts' own commitment to intensification and roll-out of IMCI work. No indicators for organizational performance and institutional capacity development were consistently tracked over time by the project, in order to understand, analyze and address shortfalls in the ability of clinics and districts to become IMCI leaders and drivers.

To be fair (and as already noted in the Context section of this report), systemic weaknesses in MOH organizational and management structures that were reflected in each of the districts where the project worked certainly influenced its planned institutional capacity development results. While there were obviously many dedicated and highly skilled individuals within district management structures that the project collaborated with, these people were and continue to be severely constrained by inadequate planning, budgeting and accountability systems. Holistic and thorough change in attitudes, motivation and organizational 'culture' of the MOH had not yet really taken hold during the lifetime of the project, in spite of improved policy frameworks, existence of donor PBAs and years of reform efforts. The gap between rhetoric and reality in health sector reform was clearly seen at the district and clinic levels involved in the MWB project, and it obviously had a huge influence on the project's effectiveness.

For example, the evaluation team saw first hand many instances where targeted districts still struggled to match IMCI service delivery requirements to their expertise and resources. The district IMCI FP position

was usually combined with other responsibilities (e.g. MCH and immunization), and there was lack of understanding among some senior managers that a dedicated IMCI role was required with clearly assigned resources and responsibilities. The issue of allowances and/or other cash incentives for various district staff to participate in IMCI activities and/or to facilitate IMCI training was still a major preoccupation. When 'top-up' allowances were not available via the project, it appeared that the quality and consistency of staff commitment to IMCI training and follow-up suffered. As well, there is the question of how effectively IMCI activities are actually integrated into District Action Plans and budgets.

The evaluation team examined four sample DAPs (three for CARE partner districts and one for a planned expansion district). They all noted child health as a key priority as well as provided some line items for IMCI training, but it was unclear whether realistic analysis had taken place to accurately cost out and account for all IMCI implementation and support requirements in the district budget. The full package of comprehensive IMCI costs would be likely to include not only health worker training and refresher courses, but such items as: 1) district staffing and on-going technical assistance to IMCI implementation and expansion, including analysis of community-IMCI data; 2) recruitment, training and technical support for community volunteers; 3) community level data collection, compilation and analysis; 3) vehicles, drivers and fuel required for regular technical support and supervision visits by IMCI FPs (not only quarterly facility assessment visits but also separate follow-up visits related to IMCI technical support, on-going quality assurance and smooth functioning of community outreach mechanisms); 4) material and logistical support for establishment and continued functioning of GMPs; and 5) procurement and continuous replenishment of the basic IMCI drug package. Several districts tried to incorporate some of these individual items into their DAPs, but none appear to have grasped the need to view IMCI holistically in both a programmatic and budgetary sense.

At the beginning of the MWB project, one positive aspect was that MOUs were signed by the project with each district to lead to gradual phase-out of project support, especially for those clinics involved in the earlier 'pilot' phase. These included clear indicators and benchmarks for handover. At least nine clinics were supposed to be phased out in the first two years of the project, but none were. While CIDA field staff may have recommended at some point that these sites not be graduated based on the progress made, the MOUs themselves were still not actively used over time as the basis for monitoring progress towards sustainability at district level (based on cost-sharing), even though they remained in place. The major focus of discussion with partners at the clinic and district levels appeared to be how to fund further health worker training, and in fact some district cost-sharing did take place on this item in particular. While this was very important, it was only one aspect of the comprehensive IMCI 'package' that districts needed to absorb and replicate.

The project evidently struggled to help districts move beyond a 'training-centric' approach and analyze the entire range of supervisory, planning, budgeting, community development, public health outreach and management/coordination skills and systems that were required to sustain and roll-out IMCI in the longer term. Given that the district basket funds did not include sufficient funds earmarked for child health as well as other problems with government fiscal management, it was tempting over the lifetime of the MWB project for districts to rely heavily on CARE as the main IMCI service provider and the evaluation team found ample evidence that is in fact what happened. As noted previously under Outcome #2, communities and clinics usually went to CARE first with major concerns or problems (e.g. equipment failures, drug shortages and training requirements etc), thereby further undermining the districts' own responsibility.

It appeared that there were several missed opportunities for the project in terms of improving clinic and district ownership. These included:

- Little or no information or coaching was provided by project staff to clinics and districts about how to organize and cost IMCI service delivery more effectively as a 'total package' as well as devise effective cost-sharing strategies with development NGOs.

- Variable support was provided to district IMCI focal points and the project did not appear to have much effect on improving their advocacy skills regarding increased evidence-based allocation of district resources to IMCI. In some districts, project staff conducted their own follow-up and technical support visits to clinics and communities separately from the IMCI FP, but in others the IMCI FP only went on field visits with project staff. In neither instance was much effort put into trying increase the impact and credibility of this key role in terms of district planning and budgeting decisions.
- Limited attention was paid to ensuring that community-level IMCI data was used effectively and consistently to support evidence-based policy, programming and budgeting at the district level.
- Little or no support was provided to district managers to lobby at the central level for allocation of a greater proportion of district basket funds for IMCI.
- Little direct strategic planning input was provided to the districts regarding how to replicate the approach being used for IMCI service delivery and community engagement in project-supported sites, with other non-project sites.

It would of course be quite unfair for the evaluation team to place the onus for any shortcomings in terms of district capacity building on CARE alone. n many cases, the district managers interviewed by the evaluation team appeared to be quite happy to let the project 'take over' IMCI in a majority of their clinics, and then take credit for what had taken place without examining the implications for the project's eventual withdrawal. At the clinic level, it was especially discouraging for the evaluation team to visit one clinic in Ndola District where CARE had worked since the project pilot phase in the late 1990s, and observe that several key issues related to C-IMCI implementation and quality assurance were not being effectively addressed either by the clinic staff members or the district even after all this time. These issues point to a combination of systemic management weaknesses in the health sector as well as severe lack of resources.

In order to provide a more balanced picture of the project's strengths and weaknesses in this area, it is important to note that CIDA did not have enough detailed interaction with the project to offer any comments or suggestions on how to address the health sector capacity building aspect of IMCI. Both CIDA and CARE probably bear equal responsibility for not paying closer on-going attention to the implications of this key issue, and for not mobilizing closer attention by the project's health sector partners regarding the risks of weak district IMCI ownership. As a result, unfortunately, in the judgment of the evaluation team, the effectiveness and quality of comprehensive IMCI services would probably decline sharply in the majority of the project's clinics and districts if they graduated from CARE support within the next one to two years. While this is a powerful argument for continuing with another phase of the project to ensure that district IMCI management capacity and ownership is fully achieved, it also points out clearly the need for both CIDA and CARE to pay much closer attention to the institutional issues that form a crucial component of IMCI.

4.4 Outcome #4: HIV/AIDS & STI Prevention and Treatment

Finding 8: The project integrated some attention to HIV/AIDS and STIs into on-going IMCI case management and community-based health education, but it is only recently that a special screening checklist on HIV/AIDS was added to the national IMCI protocol.

Outcome #4: Increase in HIV/AIDS prevention methods and STI treatment among pregnant women and caretakers of under-5s.

Supporting Outputs: 4.1 HIV/AIDS information provision strengthened; 4.2 Advocacy undertaken for improved HIV/AIDS services.

From the beginning, the project evidently tried to address HIV/AIDS mainly by encouraging CHPs to consistently provide basic prevention information to

caretakers at the community level, and by making all health workers trained in IMCI aware that HIV/AIDS could be a contributing factor for chronic morbidity among under-5s. The CHPs interviewed by the evaluation team all appeared to be quite aware of the relationship between HIV/AIDS and child health, although in practice there were still many cultural or social barriers to openly discussing the implications at the community level due to the stigma involved. The project also tried to provide better HIV/AIDS information to THs, as a means of curbing risky traditional healing practices. The evaluation team found evidence of relatively high knowledge about HIV/AIDS issues among CHPs and THs trained by the project.

Before 2005, the standard Zambian IMCI case management protocol endorsed by the MOH (and implemented by the MWB project) did not include a specific section on HIV/AIDS screening. In 2005, a new screening checklist was added that included specific areas to be covered so that health workers could try to determine if any child health issues were related to HIV/AIDS. So far, the new HIV/AIDS checklist has not been offered to all previously trained Zambian health workers, although this is the ultimate aim of the Ministry. To support this approach, the MWB project started in 2005 to offer refresher courses on the new screening protocol to health workers in its targeted districts and clinics, but as of early 2006 100% recall coverage had not yet been achieved.

Most health workers interviewed by the evaluators were well-informed about HIV/AIDS and appeared to understood that the virus could have an enormous effect on child health both directly and indirectly. For example, health workers said they tried when screening for low growth rates and chronic fevers or infections to take into account that children might be HIV-positive and refer parents to VCT clinics (where readily accessible). For pregnant caretakers, efforts were made to refer them to PMTCT services where available. In practice, it is not clear how consistently this was done. Availability of PMTCT, VCT and ART services all increased over the lifetime of the project (providing more options and incentives for referrals) due to increased funding for HIV/AIDS in Zambia, although access in rural clinics is still limited. The project evidently intended to promote advocacy on the part of communities for improved VCT services, but there was little evidence that this had actually occurred.

For Outcome #4, it was very difficult to judge precisely whether the project had made a significant contribution to change in caretaker attitudes and behaviours on either HIV/AIDS or STIs. More direct observable effects appear to have occurred for health workers and community volunteers. The annual project survey (as noted above under Outcome #1) did try to measure caretakers' knowledge of HIV/AIDS causes and means of prevention, and found quite high levels of basic understanding. However, the significance of this data was difficult to judge in isolation from broader statistics and information. Other work on HIV/AIDS has demonstrated that although knowledge of the virus and its causes may be very high, this does not always translate into behaviour change for the most-at-risk groups. Therefore, while it is necessary to continue to provide basic HIV/AIDS information (as the project has evidently done), this may not be enough to produce lasting change in practices of under-5 caretakers.

The increased focus on improving the IMCI screening methods used by health workers to incorporate HIV/AIDS and other sexually transmitted diseases, however, does make a great deal of sense. A future project phase could concentrate its efforts on continuing to improve the coverage and quality of health worker IMCI case management practices related to HIV/AIDS, given that it is now a clear policy orientation of the Ministry and can be promoted more aggressively as part of the comprehensive IMCI package. Another good possibility (already flagged by project staff) is to provide more intensive support to health workers, as well as clinic and district supervisors, in analyzing how to reduce their own risks related to HIV/AIDS both professionally and personally.

4.5 Outcome #5: IMCI M&E Information

Finding 9: The project strengthened performance measurement and analysis of basic IMCI-related statistics at the community and clinic levels. While partners gained some good knowledge and skills in data collection and use, there were also weaknesses and gaps in the project's overall M&E approach.

> Outcome #5: Collection of baseline, monitoring and evaluation information allowing partners to draw conclusions on validity of the findings and on project results.
>
> Supporting Outputs: 5.1 Development of complete M&E system to measure output, outcome and impact data; 5.2 Completion of baseline report; 5.3 Annual operational research plan to improve project components; 5.4 Workshops organized to share findings.

One of the project's major aims was to improve collection and use of IMCI-related data at various levels of the health system. This was both integrated within other outcome areas and presented as a separate outcome that combined developmental and operational aspects. CARE tried to use data collection to both measure the project's own performance as well as impart more effective strategies and capacities for on-going measurement and management of IMCI-related data by its partners. This approach appeared to be relatively effective in providing concrete skill-building on data collection, but also led to a proliferation of IMCI-related data that was not always used to its full potential and in some instances was difficult to interpret in meaningful ways (especially in relation to overall project results achievement).

The project was able to provide training on various types of simple data collection, management and use to community volunteers (NHCs and CHPs) in an effort to get them to understand and analyze child health trends at a local level. Community partners participated at all levels in data reporting and put into effect an admirable model of data flow, using zone systems at the community level for compilation and roll-up. According to what the evaluation team found, this did strengthen the knowledge and motivation of community volunteers and helped them recognize the value of evidence-based analysis of underlying causes and trends in child health. Some members of the NHCs in particular felt empowered by having responsibility for an important aspect of health data collection.

Training was also provided to clinic staff and district officials on how to utilize IMCI data from communities and clinics for tracking programming trends and issues, and to increase the quality and range of data available to be entered in the national HMIS. The evaluators found considerable evidence that tracking of key indicators related to the under-5 disease burden appeared to be much stronger and more consistent in clinics supported by the project than in non-project sites. In fact, in the districts visited, the only clinics that appeared to be consistently collecting any IMCI data at all were those trained and supported under the CARE project.

However, the evaluation team also identified several on-going, interconnected challenges with the data collection process used and promoted by the project:

- In some instances it was not clear that community volunteers really understood that the IMCI data they collected was supposed to be for their own benefit, and that they in fact 'owned' the data and could use it for advocacy purposes with health officials.
- The indicators introduced by the project for community-based data collection went well beyond the requirements of the HMIS, partly to help demonstrate ways in which the HMIS could be improved by making it more detailed in relation to child health. In practice, it appeared that collection of data for these 'extra' indicators on a monthly basis was sometimes too onerous and time-consuming for community volunteers, and that the data collected was not analyzed or used consistently anyway at various levels.

- Clinics and districts in many instances simply extracted what they needed from the detailed community data to meet their district HMIS requirements, and they often did not have time or motivation to figure out how to utilize the data to adjust their IMCI program response.
- Detailed community-level data was often transferred by clinics directly to the HMIS officer at the district level and/or to the district nutritionist (for growth monitoring statistics), but not always to the IMCI FP. Consequently, data was not being used by district officials to make evidence-based IMCI programming decisions and/or to advocate for increased IMCI resource allocations from the central level.
- The primary flow for the detailed community and clinic level data was to CARE itself for project monitoring and reporting purposes. In some instances it did not appear that communities or clinics understood clearly whether the performance data they were tasked with collecting related primarily to strengthening the health system itself as opposed to meeting certain requirements related to their participation in the donor-funded project.

Some additional points on the strengths and weaknesses of the strategies used by the project to support results-based performance measurement and reporting will be covered in Section 5 below. Overall, it appears that a great deal of 'extra' IMCI data was generated by the project that in theory was extremely interesting, but it was not always used to the fullest extent possible for improved decision-making information at the community, clinic, district and national levels. In future, it will be important to find ways to simplify data collection requirements and processes, both to demonstrate more clearly that IMCI does make a difference in child health and to build partner capacity in using the data for advocacy and resource allocation purposes.

4.6 Gender Equality as a Cross-Cutting Theme

Finding 10: The project did not have an explicit gender strategy, and the attention and analysis provided to IMCI-related gender issues was inconsistent. For example, the project did not consistently analyze the significance of the gender disaggregated data collected.

The project intended to mainstream gender issues within its original design, and the PIP included a useful gender analysis matrix that identified key gender equality challenges that needed to be addressed in relation to each outcome, as well as concrete strategies for addressing them. However, it appears that the project did not consistently focus on either implementing these strategies or in tracking their effectiveness over time. In common with many projects of this type, gender issues appeared to decline in visibility and importance during actual project implementation. The evaluation team did not analyze gender issues in the project in any depth, but it found that while there was a strong implicit recognition of the importance of gender concerns within IMCI (given that the vast majority of Zambian caretakers and health workers are women), the project did not achieve any significant gender-related results nor had it paid consistent attention to collecting or utilizing gender-disaggregated data for IMCI. In early stages, the project offered some training and sensitization on gender issues to its main partners and it appears that limited analysis of gender concerns was integrated into some training for NHCs and community volunteers, for example. However, there was no consistent follow-up to any of these activities.

The project collected some gender disaggregated data in relation to breaking down the number of male and female health workers and CHPs trained, but it was not clear how the data was used to inform on-going gender analysis and strategies. For example, it would have been very useful to understand more clearly the factors that may have limited recruitment and continuing involvement of men and women as CHPs, and whether any of the underlying social or economic factors could have been better addressed by the project or its partners. Gender equality issues would need to be addressed more coherently and consistently in any future phase.

4.7 Relevance, Cost-Efficiency and Sustainability of Results

Finding 11: The MWB project was quite relevant to health sector needs in Zambia, as well as relatively cost-efficient. However, long-term sustainability of IMCI strategies is still not assured as the key partners have become quite dependent on the project.

Based on the outcome analysis provided above (and keeping in mind the broader country, donor and institutional contexts), the following observations about project performance can be highlighted:

- The MWB project definitely played an important and strategic role in providing the MOH with a 'leg up' in IMCI implementation and service delivery (combined Outcomes #2 and #3) as well as in intensification of the community component of IMCI (combined Outcomes #1 and #2), giving a much-needed boost to improved child health as a key sector priority. In addition, efforts were made to integrate HIV/AIDS and STI awareness (Outcome #4) and improvements in health sector measurement systems (Outcome #5) into work on IMCI. The evaluation team's assessment is that individual outcome achievement varied widely, however, with estimated progress as 'low to moderate' for Outcomes #1, #3 and #4, and 'moderate to very good' for Outcomes #2 and #5.
- To the extent that they were achieved, the project results appeared to be very relevant to the needs of the primary or direct beneficiaries (districts, clinics, health workers and community health volunteers) as well as the secondary or indirect beneficiaries (children and their caretakers). The project appeared to experience some challenges in clearly distinguishing between its primary and secondary beneficiaries, perhaps leading it to take on responsibility for many levels of change ranging from institutions to individuals.
- The project achieved good cost-efficiency, in terms of the average amount expended to reach each of its primary beneficiaries under Outcomes #2 and #3 (see sidebox). However, it is difficult to judge accurately whether the IMCI activities conducted by the primary beneficiaries reached a sizable proportion of the approximately 225,000 under-5 children and their caretakers (i.e. secondary beneficiaries) originally planned for the project. Likewise, the amount directly invested to build district systems and capacity for on-going IMCI management is not known.

Calculating Project Cost-Efficiency

The latest semi-annual report available for the project at the time of the evaluation (April to September 2005) indicated that approximately 3,790 CHPs, 271 THs, 596 NHC members and 511 health workers/supervisors had been trained and/or were still actively involved in conducting IMCI activities via the project, across 47 clinics/communities in three districts. Up to the end of December 2005, approximately $4.53 M CAD or 91% of the planned project budget had been spent. The average amount invested by the project for each primary beneficiary/recipient (including training, technical support, supplies, follow-up and all administrative costs) over the lifetime of the project can therefore be roughly calculated as less than $900 CAD (or around $225 per year).

- The project's major challenge was the need to achieve on-going ownership and management of IMCI by district partners (Outcome #3). As noted elsewhere, given the challenges and risks facing the Zambian health sector during the project's lifetime and the fact that CIDA played a hands-off oversight role, some allowances must be made for these difficulties. On the other hand, CARE's expertise and comfort level as an implementing agency appeared to be much greater in relation to strengthening direct delivery of community-level services, rather than in reinforcing improved health sector management of IMCI.

In summary, the relatively strong development effectiveness of the project to date (in terms of its ability to achieve at least some of its key outcomes) has to be weighed against the risks of not being able to sustain these efforts given the many systemic capacity and funding weaknesses in the health sector as a whole and at the district level in particular. These issues will need to be carefully factored into design and implementation of any future phase of the MWB project, as CARE and CIDA are already aware.

5. Project Success Factors: Management and Operational Issues

The following section provides an overview of findings related to project management and operations (as per WBS 600 in the project's performance framework), including brief comments on CARE's management and operational capacities. Analysis is provided for each of the key success factors (partnership, appropriateness of design, resource utilization and informed and timely action) in terms of whether they enabled or hindered results achievement.

> What has been the degree of overall efficiency and effectiveness of project management strategies, in terms of their ability to support results achievement?
>
> What are the operational capacities of CARE Canada and CARE Zambia for effective project management? What are the strengths and weaknesses of the two agencies in terms of their ability to support future programming initiatives of this type?
>
> To what degree have key success factors such as partnership, appropriateness of design and resource utilization, and informed and timely action been met?

5.1 Project Management

Finding 12: The project's management tools and systems met RBM requirements, but workplans and reports had some weaknesses. There was poor integration between financial and narrative reporting and the performance measurement system was too complex and cumbersome to be used effectively to support performance analysis.

There were several positive aspects to the project's overall management process:

- Individual project managers and staff members were all highly skilled and dedicated individuals, who displayed high levels of professionalism and commitment in relation to the project's aims. The project has had the advantage of being able to attract talented individuals from within the health system with strong practical experience in IMCI implementation.
- Reports and documents produced for CIDA were well-organized and delivered in a timely fashion for the most part. The major responsibility for generating project reports was with CARE Zambia, and CARE Canada added value as required.
- Financial management and reporting systems for the project appeared to be quite strong and met CIDA's financial, accountability and audit requirements.

The following observations can be made about areas for potential improvement:

- Many of the key development results found in the project's LFA could have been more clearly and precisely defined with relation to the scope of change desired and the precise beneficiary or target group, which would have improved their measurability. The design of the project's results logic did not always demonstrate clearly that the identified outputs would actually lead to the desired outcomes. The early project design was evidently quite experimental and probably required more on-going practical analysis and adjustment to be fully functional.
- Semi-annual reports to CIDA covered only each six month period and did not include cumulative annual assessments of progress towards development outcomes. Reports were mainly descriptive and concentrated on activities and indicator data, but little or no performance analysis was provided in terms of medium- to long-term results.
- The project workplans did not meet minimum RBM requirements (even though they were accepted and approved by CIDA). The workplans were presented in the form of GANTT charts without any supporting narrative or analytical information on strategies for results achievement. They were not sufficient to be used as the basis for results-based reporting.

- The PSC meetings do not appear to have been used strategically by either CARE or CIDA to focus attention on critical analysis of on-going project performance, shortfalls and risks. PSC meetings did not live up to their full potential, in terms of engaging the donor and GRZ stakeholders in critical dialogue on how to link the project more effectively to the evolving health sector context.
- Financial reports were submitted separately from narrative reports, and no attempts were made to link financial expenditures to results progress so that the two could be analyzed in an integrated manner.
- As already mentioned in the precious sections, there were many challenges with the quality and viability of the project's performance measurement system and the utility of its linkages to the broader HMIS. Information from the annual project surveys were not fully integrated into the project reports, and it appears there were difficulties and gaps in synthesizing and interpreting indicator data to support on-going performance analysis. Firstly, the rigor and utility of the project's own baseline survey may have been questionable. Secondly, the design and use of a large number of discrete, project-specific indicators to try and capture percentage changes in samples of targeted populations was probably not statistically or technically sound, and it led to a proliferation of data that was difficult to interpret clearly. Thirdly, the annual surveys (as noted above) were not used effectively to support performance reporting. Fourth, to some extent the project set up a parallel system for collecting community level information on child health for its own monitoring purposes. In theory, this information could have been used to improve the range of data available for the HMIS but this did not take place. Neither was this data always used effectively at the district level for evidence-based decision making on child health programming. Finally, it appeared to be have been quite challenging for either CIDA or the MOH to grasp exactly what was being derived from measurement efforts in the project, leading to some skepticism about the entire M&E system.

As stated previously, CIDA also bears some responsibility for management issues given that little active feedback was provided to CARE at critical junctures. Discussions with both CARE and CIDA over the course of the evaluation revealed that the key stakeholders were already aware of many of these issues, and wished to focus their joint efforts on improving performance management and measurement functions in a future phase.

5.2 CARE Management and Programming Capacities

Finding 13: Both CARE Canada and Zambia have well-developed program management capacities. Coordination between the two agencies is good, but some gaps may exist in sharing technical expertise and aligning performance and accountability approaches.

It was well beyond the scope of the evaluation to conduct full organizational assessments of either CARE. However, some efforts were made by the evaluation team to understand the underlying organizational and programming structures of both agencies (as well as related systems for inter-agency cooperation), both to reveal any organizational features that might have affected past performance and to ascertain what influence they could have on a future phase.

The following key issues and their implications were noted:

- Not surprisingly, CARE Zambia and CARE Canada are both very much oriented towards self-managing projects. Generally, the MWB project staff members were left on their own by senior managers to plan, implement and adjust their strategies as needed over the life of the project with relatively limited amounts of technical or strategic input from senior experts and managers. These structures and systems appeared to work well if the MWB project was viewed simply as a discrete, one-off investment in line with most traditional NGO projects. However, there are some

limitations to this approach in a programming environment where project-based support has to be linked more closely to sector approaches. CARE Canada did offer some useful specialized health sector expertise to CARE Zambia during the project, but the availability and scope of these inputs are constrained both by the size of the overheads allocated CARE Canada, as well as the fact that the technical advisor was only in the field occasionally and may not have been well-informed about the complex health reform process and its effects on IMCI work. CARE Canada could possibly provide better technical support for CARE Zambia's health programming in future by helping analyze the risks and implications at the sector level for project-level work. As well, both CAREs could consider increased use of technical consultants to provide strategic advice on how to better position its health investments, and/or consider creating much closer analytical ties with CIDA's health sector specialists.

- Managers and senior staff members at both CAREs are quite knowledgeable about results and performance management systems and tools for development projects. Training on RBM was offered in the past at both the agency and project levels, and CARE Zambia has worked with a variety of donors in responding to results-based planning and reporting requirements. However, within the MWB project, it appears as though neither CARE paid much attention to ensuring that the performance management systems evolved and were updated as needed over time, and that new project-level staff were well-briefed and/or received refresher training on CIDA's particular RBM requirements. For example, the same workplanning and reporting formats used at the start were simply inherited and recycled by subsequent project managers and staff members, without critical guidance from senior managers in either agency about their proper use. In-house RBM training, coaching and technical input was not offered regularly to project staff even though both agencies have suitably skilled resource people who could provide this service.
- The relationship between CARE Canada and CARE Zambia in terms of oversight and accountability for project performance and results appears to be quite fluid, based on the strong sense that both agencies are autonomous development partners and therefore should not interfere with each other. CARE Canada appears to have played a largely 'hands-off' role during the project, except for substantial support provided to financial reporting. This approach may have led to some gaps in terms of either CARE taking the initiative to step back and critically assess how well the project was really doing in terms of making progress towards its results (even in the absence of feedback or prodding from CIDA). At no point was rigorous internal performance monitoring or review of the MWB project conducted, in order to systematically analyze many of the same performance issues that were covered in the external evaluation. This could have been done jointly by both CAREs, with input from senior program managers and health specialists/advisors, or led by one with input from the other. At the very least, CARE Canada staff who visited Zambia on a fairly regular basis could have worked more closely with CARE Zambia managers and staff members (both project and non-project) to conduct in-depth performance review visits to project sites, jointly analyze and assess progress towards results, assess emerging risks or challenges, and provide more intensive technical support in preparing annual workplans and reports.

Overall, the evaluation team concluded that CARE Zambia and CARE Canada provided very competent joint management for MWB, and were able to utilize their available programming and management resources relatively effectively to support project results achievement. Obviously, issues such as staff turnover that were beyond the project's control need to be taken into account. Prospects for learning from the current project and further improving inter-agency cooperation and mutual accountability in future appear to be quite good. However, CARE may need to expand its current in-house resource base and propose a slightly different set of technical resources in the next phase, if more attention is required to institutional sustainability. For example, more personnel may be required with experience and knowledge in reform of health systems and public health management, in order to provide credible input at the central, provincial and/or district levels on how to better integrate IMCI as a core program.

5.3 Key Success Factors

CIDA's Framework of Results and Key Success Factors identifies several areas related to operations and implementation that are likely to have a strong influence on project performance. Most of these have already been alluded to in the preceding sections, but are summarized below for easy reference.

- ***Effectiveness of Resource Utilization***

Financial management systems were good and met CIDA requirements for timeliness and probity. Financial accounting systems at the field level were very detailed and rigorous enough to provide effective oversight of project funds. Procurement was done in alignment with CIDA norms and standards. Although it is difficult to correctly determine the percentage of overhead in relation to programming expenditures, the available financial information seems to indicate that it was in the 20-30% range, which is normal for projects of this type and meets CIDA FRAU requirements.

- ***Partnerships***

For the most part, respectful, trusting and mutually beneficial partnership arrangements were established. The project required many strong working relationships (both internal and external) at different levels. Internally, organizational and program coordination between CARE Canada and CARE Zambia was relatively strong, although more attention to alignment of technical support, performance accountability and performance assessment functions would have been beneficial. Externally, the project forged strong working relationships with others working on IMCI initiatives, ranging from the national to community levels. At the central level, key project staff members were able to liaise with national working groups on IMCI and child health in order to have some input into policies and training mechanisms. Within districts, the project staff had excellent day-to-day linkages, communication and coordination mechanisms with officials and supervisors, although this led to some dependency on the project. Overall, however, the strategic partnership between CIDA, CARE and the GRZ could have been slightly more effective in critically analyzing the effectiveness of the project within the broader health sector context.

- ***Timeliness of Feedback and Decision-Making***

The project produced and compiled a large amount of survey and indicator data from a variety of sources, based on the understanding that this information was required to judge results effectiveness. The project used annual surveys as well as community and clinic coverage or service delivery data to try and track its key indicators, in combination with regular discussions and interactions with its main project partners (districts and clinics) to monitor on-going activity implementation. While the intention behind these processes were excellent, in practice the indicator data generated was not always 1) precise and clear enough to measure developmental change in a meaningful way, and 2) analyzed and used effectively by the project and its partners to support performance diagnosis and corrective action.

- ***Appropriateness of Design***

The original project design made sense in some respects but contained flaws in terms of how clearly and realistically the outcomes were defined. Ultimately, even though it tried very hard, the project was not able to create all the changes it envisioned in regards to multiple IMCI implementation and management processes at different levels with such a wide range of beneficiaries (e.g. caretakers and under-5 children, community volunteers and organizations, health workers, clinic managers and district officials). The project also struggled to clearly define the type of institutional change required within districts to sustain and replicate IMCI in the long-term. The project design probably required more active scrutiny by CIDA and CARE over time to adapt more effectively to emerging risks and lower-than-expected performance due to emerging challenges with the capacities and resources of district partners.

6. Conclusion, Lessons and Recommendations

The following section provides an overview of the main conclusions, lessons and recommendations based on the data collected during the evaluation, which was analyzed qualitatively to identify themes, trends, issues and learnings that may help shape design of a future phase of MWB. Forward-looking lessons and recommendations have been combined due to the fact that they are integrally linked. The data was.

> What are the overall programmatic and developmental effectiveness, relevance and sustainability of the current project?
>
> What programming and operational lessons can be identified?
>
> What concrete and constructive recommendations can be made regarding the improvement of developmental and operational performance of the current project, and (more significantly) for design of the next phase?

6.1 Conclusions

There is good evidence that the MWB project contributed to many *positive effects* on the health of under-5 children and on their access to health services in the targeted districts and clinics, especially by strengthening the community component of IMCI. Statistics from the clinics where the CARE project was active, show that in many instances *the morbidity rates for under-5 children either stabilized or were reduced for diarrhea, malaria and ALRI*. However, due to systemic weaknesses in the HMIS and in the project's own data systems, it is difficult to establish clear conclusions and comparisons in all cases.

MWB provided a useful 'living laboratory' by demonstrating how the community component of IMCI can be effectively implemented in order to reduce the disease burden for under-5 children through an *integrated, multi-level approach*. It was relatively successful in making progress towards its outcomes, in terms of *influencing the skills and knowledge of caretakers* about how to prevent common childhood illnesses, *improving the scope and quality of health worker training*, *improving IMCI case management* for targeted districts, and *engaging community volunteers* as key resources and actors in child health. As well, the project had some strategic influence on the national health system's approach to IMCI, through helping to *improve and revise IMCI training methods*.

For pragmatic and understandable reasons, the project's effects were limited to directly addressing only a small proportion of the country's needs in IMCI. The project was active in three districts in Zambia (one each in Northern, Copperbelt and Lusaka Provinces), out of 72 in the entire country. As such, it operated mainly as a *'demonstration' project* so that presumably the same strategies and approaches used could be replicated in future either by the government or other donors interested in investing more resources in IMCI service delivery expansion.

The project was *less successful in demonstrating that replication and roll-out of comprehensive IMCI by the Zambian health system can be sustained*, although it appears that a great deal was learned from these efforts that could be applied fruitfully in future phases. While supervision and coordination of IMCI were strengthened at the clinic level, the project was *not able to ensure full transfer of IMCI coordination and management to the District Health Management Teams* in areas where the project was working. The three districts involved in the current project are still highly dependent on CARE support in order to implement IMCI, and they express a strong reluctance to graduate from the project (even though in two districts, some clinics have been supported for five years or more). Districts were not fully committed financially and operationally to IMCI and had not yet understood the need to strategically link the many 'threads' that comprise IMCI into one comprehensive service delivery model with concrete budgetary allocations. As a result, the project was *unable to phase out CARE support on a timely basis* as originally planned in the PIP.

Admittedly, any intervention of this type in the health sector is extremely complex and multi-faceted, and may take many years to achieve. Given the challenges facing the Zambian health system during the lifetime of the project, it is beyond the ability of any one intervention to affect systemic change at all levels. Key management weaknesses and resource gaps prevented districts from taking full ownership of IMCI without on-going technical support from CARE. Most significantly, the donor basket funds

dedicated to district support evidently did not include sufficient earmarked funds for child health. Health care reform has not yet created a sound enough platform of provincial and district management skills on which to base IMCI. CIDA also shares some joint responsibility with CARE for these sustainability challenges, as the project needed to be more strategically linked to broader issues at the central policy and funding level in order to achieve its aims. As such, future projects in this area will require closer on-going monitoring in order to ensure they achieve their aims.

In summary, MWB Phase II was a very strong project. CARE and its project staff are to be congratulated for their diligence in advancing the IMCI agenda, but the benefits achieved so far may disappear or attenuate over time without a rigorous strategy for more intensive and multi-layered capacity building support for the GRZ, especially at the provincial and district levels. It will be crucial for CIDA and CARE to cooperate closely to organize a smooth transition to the proposed next phase, which may include preparation and approval of a no-cost extension in lieu of bridging funds, as well as close cooperation on design and in strategic analysis on how to best align with the health sector context. In the opinion of the evaluation team, a future phase is fully justified but it will require intensive analytical investment from both CARE and CIDA (as well as a clear division of labour and strategy for on-going cooperation between the two agencies at different levels of the health sector) to ensure that it provides a viable and sustainable contribution to the Zambian health sector.

6.2 Lessons and Recommendations

6.2.1 Programming Lessons and Recommendations

Exhibit 6.1 Programming Lessons and Recommendations

LESSONS	RECOMMENDATIONS [3]
PL1. Strong expertise in and consistent use of community health promotion techniques is required to support effective implementation of the community component of IMCI. Specific training and outreach strategies can be used for mobilizing communities to engage in IMCI but these appear to be relatively new for many in the Zambian health sector.	PR1. CARE should continue build on and learn from its own experience in implementing IMCI at the community level in future projects, but should place a stronger focus on finding techniques to build the capacity of the health system itself for replicating and sustaining the strategies used to 1) recruit, train and empower community organizations and volunteers (e.g. NHCs and CHPs), and 2) support child health promotion activities (including strengthening of Growth Monitoring Points). In future phases, the focus should be on ensuring that health workers and health institutions (mainly clinics and districts) have the practical knowledge, resources and motivation to replicate and sustain community-based public health outreach models that empower community members and volunteers.
PL2. Traditional Healers (THs) play an important role in community health, and with proper support and encouragement they can be effectively engaged to become full partners in child health activities. If treated with appropriate respect, THs can be mobilized to do referrals and to support health workers in addressing many issues related to child health.	PR2. Similar to the above, only with an additional focus on promoting the tools or strategies required by those within the Zambian health system to continue to work more effectively with THs as a key community resource and partner to promote child health.

[3] Detailed comments on the draft proposal for the next phase that incorporate many of the issues raised in the MWB evaluation can be found in Appendix VI of this report. Rather than provide specific recommendations on the design of the proposed next phase in this section of the report, the evaluators would like to refer readers to these comments.

LESSONS	RECOMMENDATIONS [3]
PL3. Motivated community volunteers are essential to implementation of C-IMCI, but NGOs and the health system cannot assume that volunteers (many of whom are women) do not require monetary incentives.	PR3. CARE should continue to research and document in future phases the issue of volunteer incentives and support at the community level by assisting its health sector partners to experiment with different models and approaches for use in IMCI, including building monetary incentives such as honoraria into district health budgets. This could include work on harmonization of broader policies and strategies for volunteer incentives with the MoH and among key donor agencies involved in community health practices, in order to come with a coherent long-term approach that covers all community volunteers (not just those related to IMCI). It might also involve finding ways to consolidate or merge the existing CHW system with IMCI volunteers, rather than creating new cadres that may not be fully integrated into the health system in the long run.
PL4. Health workers can be trained, motivated, equipped and supported to provide very effective IMCI case management, even in isolated or low-resource situations, but this requires continuous quality assurance, refreshers, technical support and encouragement.	PR4. CARE should continue to focus on ensuring that Zambian health partners can maintain the quality and consistency of IMCI case management practices and protocols among health workers (via training, refresher courses and other means), while at the same time encouraging the health system to assume these quality assurance responsibilities in the long term to alleviate any risk of dependency on an external agency such as CARE for on-going support. It may be useful to document more explicitly the full range of methods used to support health workers in IMCI case management and service delivery, that is, not only supervisory visits but also technical and coaching support to sustain quality processes and skills related to public health interaction and collaboration. Greater attention should be paid to analyzing the incentives (both monetary and non-monetary) required for clinic health workers to implement IMCI and find ways to ensure that at least some of these incentives are built into health sector budgets and plans.
Note that in relation to the above four recommendations, CARE should consider integrating a small operational research component into any future project phase (possibly in collaboration with an external research agency or university), in order to capture and analyze more systematically its contribution to international IMCI theory and practice especially in regards to lessons and strategies for effective implementation of community IMCI.	
PL5. It has been much more difficult and complex than anticipated to build district capacity to take over IMCI programming, and to phase out project support. Districts have a strong tendency to lean on CARE as the lead IMCI service provider. Institutional change is required to build and sustain IMCI planning, budgeting and oversight, which requires much more than simple provision of supervisory training to individual staff or managers.	PR5. For the next phase, rather than focus on rapid scale-up or roll-out of IMCI at the country level, CARE should consider reinforcing long-term IMCI sustainability and effectiveness by focusing more explicitly and rigorously on how to conduct strengthening of planning, budgeting and programming skills and systems with both provinces and districts. Strategies could include conducting institutional capacity assessments to identify assets and gaps in IMCI management procedures, as well as interacting more closely with provinces and districts in their strategic planning and budgetary processes to coach them on how to ensure that adequate strategies and funds are allocated for IMCI, and that the National IMCI Planning Guidelines are improved and applied as required. As well, a more rigorous exit strategy at this level needs to be developed and adhered to, with regular meetings to discuss the progress of cost-sharing plans with districts. CARE should also ensure that it recruits personnel for the next phase with adequate expertise and credibility in health sector management to support institutional reform and capacity-building at higher levels of the health system.

LESSONS	RECOMMENDATIONS [3]
PL6. The project's relative isolation from other CIDA programming investments in the health sector has created missed opportunities for both CARE and CIDA in terms of transferring learning and information between parallel or complimentary initiatives to create a more coherent Canadian profile in the health sector.	PR6. CIDA and CARE need to ensure that any future phase of MWB is closely linked in some way to new or on-going Canadian health sector investments, such as support for human resource development in the health sector and improved drug procurement systems. A huge amount of 'bottom up' learning from IMCI implementation (in terms of how to motivate health workers and improve rational drug use at the clinic level) is of direct relevance to design of other CIDA investments, and vice versa. The lead stakeholders need to remain fully engaged with each other on a regular basis to inform each other of their respective information on the health sector's needs and issues (see also OR5 below).
PL7. Project-based support in the Zambian health context risks being a waste or having many of its planned results compromised, unless it is linked more aggressively and consciously to parallel support for health sector reform via PBAs.	PR7. In the context of its future country programming strategy in Zambia, CIDA should contribute directly to PBAs in the health sector to leverage increased national and donor support for child health and ensure that project-level investments are financially and institutionally sustainable. Specifically, CIDA should consider making direct investments in district basket funds that are earmarked for child health and can be utilized at the district level to support the full spectrum of IMCI services and activities. As well, CIDA and CARE should create stronger strategic linkages at the national level to lobby with government and donors for improved IMCI allocations within district budgets. CIDA should also consider (in close coordination with CARE) direct participation in various national policy working groups and committees on child health to advocate for adequate resources for sustainable, decentralized management of IMCI.
PL8. Gender equality and HIV/AIDS issues were not fully integrated within the original project design and implementation, mainly due to a lack of an overall strategy, consistent attention and earmarking of activities and resources to these areas of work.	PR8. Future phases of the project should revisit the original project gender matrix (which was relatively good) to see what ideas could be brought forward more consistently and strongly in a detailed, costed gender action plan that is fully integrated with the new project WBS. CIDA should also consider if more resources need to be invested in hiring an external gender consultant (either Canadian or Zambian) to be more closely involved with helping the project plan and monitor its gender strategy, and/or whether CARE Zambia could access any internal technical support on gender from CARE Canada or from within the CARE network. In relation to HIV/AIDS, CARE should focus attention in the next phase on ensuring that the new HIV/AIDS checklist is fully integrated into IMCI case management (through both refresher and new training with health workers) and that the checklist is consistently used by health workers. As well, stronger efforts should be made to ensure that community-level health promotion activities (at clinics or GMPs) consistently offer accurate and up-to-date HIV/AIDS prevention and treatment information.

6.2.2 Operational Lessons and Recommendations

Exhibit 6.2 Operational Lessons and Recommendations

LESSONS	RECOMMENDATIONS
OL1. The original project design was probably over-ambitious in some respects, and at the same time many results were not defined as clearly and precisely as possible (both outputs and outcomes). The project sought to produce change at multiple levels (and with multiple beneficiary groups) including individuals, communities and health institutions, and therefore experienced some important challenges in meeting and measuring all planned targets and results because its scope of work was so broad.	OR1. CARE and CIDA should invest considerable analytical resources in producing a new project design that is based on participatory, multi-stakeholder mapping of the project's performance logic, and ensure that all results are clearly defined, realistic, achievable and measurable, particularly in relation to provincial and/or district capacity building and ownership. In particular, a clearer distinction should be made between the new project's primary and secondary beneficiaries, at both the individual and institutional levels, in order to more precisely define its main areas of concentration for results and activities.
OL2. The PSC meetings were not used strategically to analyze performance issues in the project, nor to explore the linkages between central policy and budgeting issues and what was happening at the level of implementation.	OR2. CARE and CIDA should develop a new joint approach for planning and implementing more strategic, performance-oriented PSC meetings in future project phases. If possible, senior decision-makers from key partner agencies need to be involved more consistently and the meetings managed more effectively to focus analytical attention on the relationship between central policy and funding decisions, and any challenges encountered with IMCI implementation and ownership at the provincial, district and community levels.
OL3. Project workplans, reports and budgets were not designed and used as effectively as possible as tools for results and performance management.	OR3. CARE should concentrate on developing a closer linkage between programming and budgeting in any future project, and demonstrate this clearly in on-going workplanning and reporting, by depicting how the level of expenditures relates to the level and scope of results achievement (perhaps by introducing output or activity-based budgets). Workplans in particular need to be improved and made more performance-oriented, so that planned activities are linked clearly to desired outputs and outcomes. Reporting should be made more results-focused, so that there is evidence-based analysis of progress towards outcome achievement, especially on an annual basis. Finally, it is essential that there be clearer documentation of any shifts in key results, plans or strategies on an annual basis, and that stronger attention be paid by both CAREs to developing processes for stronger internal project performance review and monitoring. In order to support the above, CARE Canada and CARE Zambia should collaborate in ensuring that key project managers and staff members all have consistent (and regularly updated) knowledge and skills in RBM.
OL4. The performance measurement system used by the MWB project was quite ambitious and complex. While this system reinforced several important programming aims (in terms of building data collection and use capacities among key partners), it was also time-consuming and led to a proliferation of statistics and numbers at different levels that was not always used very effectively by partners or the project.	OR4. CARE should focus in any future project for IMCI on designing a system for both internal project performance measurement and to reinforce partner capacities in analyzing community health issues, that is as simple, streamlined and easy-to-understand as possible. As well, a stronger focus should be put on ensuring that performance data is effectively transformed into results-based performance analysis for the donor and key partners, in order to support better evidence-based decision making at a number of levels.
OL5. In the current MWB project, CIDA and CARE were somewhat disconnected in terms of coordinating their support for GRZ child health activities at different levels.	OR5. CIDA and CARE should focus on establishing closer field collaboration mechanisms during the next phase of MWB. Regular meetings and strategy sessions need to be held between CIDA and CARE at the field level to discuss project progress and decide how the information from project implementation can be used to either 1) increase the strategic value of other CIDA investments in the health sector, and 2) improve leverage for more resources and better policies for child health at the national level.

LESSONS	RECOMMENDATIONS
OL6. CIDA's 'visibility' and profile as a lead donor for community-based implementation of IMCI was compromised by the lack of credit provided to the Agency in some key documents where CARE participated as a resource.	OR6. In future, CIDA should be credited explicitly as a supporting donor in any documents, tools, or information released on IMCI where CARE (via the MWB project) has played a contributing role as a result of CIDA funding.

Appendix I Evaluation Terms of Reference

TERMS OF REFERENCE
FOR EVALUATION OF THE MOYO WA BANA PROJECT
CARE CANADA
November 2005

1. INTRODUCTION

CIDA requires the services of a two-person Consultancy team comprising health and evaluation specialists. The assignment involves evaluating the results of a CIDA funded health project for children in Zambia managed by CARE Canada, as well as input into the design of a follow-up phase of the same project. While recognising the value of an international evaluator on these issues, CIDA is also acutely aware of the need for an evaluation such as this to be useful, relevant and linked to national research agendas as much as possible. To this end, CIDA will work with a Zambian health specialist who is familiar with the issues on the ground and linked in with local policy debates. A Canadian evaluator will serve as the Evaluation Team Leader responsible for overall execution of the assignment, bringing experience of CIDA requirements for evaluations, while the health specialist will assist with the technical components.

2. BACKGROUND

Moya wa Bana means "the life or health of children". The current Moyo wa Bana (MWB) Project Phase II aims to assist Zambia to improve the health of under-five children using the integrated management of childhood diseases (IMCI) approach, particularly in relation to the prevention of malaria, diarrhoea and Acute Lower Respiratory Infections (ALRI). The MWB Project also promotes HIV/AIDS awareness and behaviour change as a way of consolidating the health and survival of children through healthy parents. The Project began in July 2001 and runs until April 2006 with a budget of $5 million. It operates in three areas of Zambia: Kasama in the Northern Province, Ndola in the Copperbelt Province and in the capital region of Lusaka. The MWB Project works in close collaboration with the District Health Management Teams (DHMT) and the Central Board of Health (CBOH). The Project targets close to 150 000 children under five, 65 000 mothers, as well as 375 000 other household members.

The MWB Project has the following objectives at the **Outcome** level:

- Reduced incidence of the leading cause of death among under-five children (malaria, diarrhoeal disease and ALRI as a result of: i) changed household practices; and ii) improved delivery of community-based health services by Community Health Promoters (CHPs), Neighbourhood Health Committees and clinics in the areas of malaria, ALRI and diarrhoeal diseases.
- Reduced spread of HIV/AIDS and STIs as a result of: i) changed individual behaviours (safer sex, seeking testing, counselling and treatment); ii) appropriate education and information from CHPs in collaboration with clinic staff; and iii) improved quality and scope of services and referrals provided by clinic staff.

To achieve these results, the Project carries out activities which include capacity building for health care workers in the delivery of IMCI; strengthening of the relationship between health centres and their catchment areas through NHCs and CHPs; provision of equipment and supplies to health centres for the delivery of IMCI; training in drug use and logistics; supplementation of Vitamin A stocks for children and some provision of essential drugs; community-based plans for HIV/AIDS, including voluntary testing and counselling, with a focus on assisting mothers or fathers who are or suspect they are HIV positive (as opposed to just contraception).

The follow-up Phase III of the MWB Project proposes a major scale-up of activities and coverage to the tune of $25 million over five years, of which $20 million would be a CIDA contribution. Scale-up will involve building on lessons learned under Phase II and extending the MWB Project from the three sites of Kasama, Ndola and Lusaka to sites within the remaining six provinces. Scale-up will also comprise the development and integration of project systems within the national health infrastructure contributing to Zambia's being able to meet Millennium Development Goal 4: *To reduce by two-thirds between 1990 and 2015 the probability of children dying between birth and five years of age.*

The **Goal** of the proposed Phase III Project is to enhance Zambian development prospects through improved child health survival and its **Purpose** is to develop sustainable health system and community capacity to decrease morbidity and increase the well being of children under the age of five years. The difference between the current and proposed next phase is the latter's focus on contributing to the development of the Zambian health system to promote the well-being of children under five.

3. OBJECTIVES OF THE ASSIGNMENT

The objectives of the assignment are:

- To evaluate the results of Phase II of the MWB Project.
- Drawing upon lessons learned from Phase II of the MWB Project, to assist CIDA and CARE Canada with a critique and recommendations to the current proposal and design for a follow-up Phase III.
- To assess the capacity of CARE Canada vis-à-vis the proposed level of effort for Phase III and provide recommendations for appropriate adjustments if any.
- To analyse the causes of high childhood illnesses in the target areas and recommend how CIDA and CARE Canada through the Phase III MWB Project can more effectively address these.
- To assist CIDA with the development of project approval documentation for the proposed follow-up phase, including background analysis of the health sector in general, and of children's health and IMCI.

4. SCOPE OF WORK

Background

The Consultants will begin the assignment in early November, approximately two weeks prior to the mission in Zambia in late November. The Consultancy team will be comprised of a Canadian evaluation specialist and a Zambian health specialist, each with a distinct mandate. The evaluation specialist will serve as the Evaluation Team Leader.

CIDA's Role

The CIDA Project Team Leader (PTL) will serve as the HQ Evaluation Manager and will represent the Agency during the review. She will guide and coordinate the activities of the evaluation, including setting the Terms of Reference, approving the work plan, providing feedback to the consultant on drafts and approving the final report.

Specifically, the HQ Evaluation Manager will:

- Contract a qualified Canadian evaluation specialist, who will serve as the Evaluation Team Leader;
- Have overall responsibility and accountability for the evaluation;
- Provide guidance throughout all phases of the evaluation process;

- Approve all deliverables; and
- Coordinate the Agency's internal review process.

The Acting PSU Director will serve as the Field Evaluation Manager and will provide input in analyzing the Terms of Reference, work plan and report. Specifically, the Field Evaluation Manager will:

- Contract a qualified Zambian health specialist, who will provide technical input into the evaluation.
- In consultation with the HQ Evaluation Manager, provide guidance and assist the Evaluation Team Leader throughout all phases of the evaluation process;
- Provide analysis and input into all deliverables;
- Coordinate the review process in the field and liaise with the HQ Evaluation Manager.

Role of the Evaluation Team Leader

The Evaluation Team Leader, informing both the HQ and Field Evaluation Managers, will be responsible for conducting the review in conformity with the principles, standards and practices set out in the CIDA Evaluation Guide (2004) and undertaking the following activities:

- Drafting and finalizing the evaluation work plan;
- Conducting the evaluation;
- Managing the day to day operations of the evaluation;
- Regular progress reporting to the Field Evaluation Manager.
- Production of deliverables.

The Evaluation Team Leader will guide and oversee the activities of the Canadian-based health specialist.

The Evaluation Team Leader will prepare a work plan that will operationalize and guide the evaluation. The work plan will describe how the evaluation is to be carried out, bringing refinements, specificity and elaboration to these ToR to clearly identify their role and that of the health specialist. The work plan will be approved by the HQ Evaluation Manager and act as an agreement between parties for how the review is to be conducted, encompassing the following elements:

- Background to the Project and Evaluation Assignment.
- Expectations of the Evaluation.
- Roles and Responsibilities.
- Methodology.
- Evaluation Framework.
- Information Collection and Analysis Methods and Tools.
- Reporting Outline.
- Work Scheduling.
- Level of Effort and Budget.

The evaluation will include site visits in either of Kasama or Ndola and Lusaka, whereby the Evaluation Team will meet with CIDA and CARE Canada field personnel and project stakeholders in the country to collect information in accordance with the requirements stipulated in the work plan. Prior to mission, the Evaluation Team Leader will also meet with CARE Canada MWB Project staff in Ottawa. The Evaluation Team Leader will guide and supervise the field mission and lead team briefings to CIDA field personnel. The Evaluation Team Leader will also prepare the draft and final versions of the evaluation

report in conformity with the principles, standards and practices set out in the CIDA Evaluation Guide (2004).

Deliverables expected from the Evaluation Team Leader
The Evaluation Team Leader will prepare the following deliverables, in English, and submit them to CIDA' s Evaluation Manager electronically via e-mail and in hard copy:

- Draft Evaluation Work Plan, within one (1) week of contract signing.
- Final Evaluation Work Plan: within one (1) week of receiving comments on the draft work plan.
- Lead Field Mission Briefings to CIDA field personnel.
- Draft Evaluation Report: two (2) hard copies are to be submitted to CIDA and CARE Canada, following the approved work plan and in accordance with standards identified in the CIDA Evaluation Guide.
- Final Evaluation Report: within two (2) weeks of receiving comments from CIDA and CARE Canada on the draft evaluation report. The Consultant will submit an electronic copy as well as two (2) hard copies of the Final Evaluation Report in English, including an abstract/executive summary.

All deliverables will become and remain intellectual property of CIDA.

Role of the Health Specialist

The Health Specialist will inform the Evaluation Team Leader and will undertake the following activities:

- Review Project Documentation/Evaluation Work Plan, in preparation for the field mission to Zambia.
- Participate in Evaluation Field Mission, which will include site visits and meetings with CIDA and CARE Canada field personnel and project stakeholders, to support the assessment of the MWB Project's achievement of expected results, outstanding successes and lessons learned, and intended/unintended results; current operational capacity and performance of CARE Canada as an organization; and, to identify any recommended changes required to improve the MWB Project's performance.
- Participate in Field Mission briefings with CIDA field personnel, on arrival and before departure, in accordance with the requirements stipulated in the Evaluation Work Plan.
- Contribute to the preparation of draft and final Evaluation Reports, in accordance with the requirements stipulated in the Evaluation Work Plan.

Deliverables expected from the Health Specialist
More specifically, the Health Specialist will be responsible for the following deliverables and will submit these to the Evaluation Team Leader:

- Data collection and documentation of field mission findings regarding the MWB Project and IMCI in Zambia, and CARE Canada as an organization, in accordance with the requirements stipulated in the final Evaluation Work Plan.
- Written inputs for the development of the Draft Evaluation Report, in accordance with the requirements stipulated in the final Evaluation Work Plan.
- Written inputs for the development of the Final Evaluation Report, in accordance with the requirements stipulated in the final Evaluation Work Plan.

All deliverables will become and remain intellectual property of CIDA.

5. WORK DESCRIPTION

A specific description of the work involved is provided below. The Consultants, however, will be responsible for ascertaining and following up on any other elements as necessary to produce the deliverables required. The evaluation will cover the following elements:

Achievement of Results

Examine in detail the progress made towards the achievement of expected results as outlined in the Logical Framework Analysis, identify gaps and constraints that remain to be addressed and propose strategies for addressing them in a sustainable manner in the follow-up Phase III. Identify and document successes and problems faced, how effectively the project is operationalized in practice and assess the financial and administrative challenges to scaling up as per the CARe Canada proposal.

Appropriateness of Design

Examine the Project's current focus, as well as that of the proposed follow-up project and assess what strategic alterations or concentrations would be advisable.

Sustainability of Results

Examine the sustainability of Project results and how the proposed follow-up Phase III can operate more effectively given current levels of capacity of partner organizations/institutions (including Zambia's Ministry of Health, the DHMTs, CBOH, CHPs, NHCs, etc.), especially with reference to financial, human resource and operational capacity constraints.

Cost-Effectiveness of Results and Appropriateness of Resource Utilization

Assess the appropriateness of the level of disbursements relative to the results achieved, as well as the appropriateness of the budget for the proposed Phase III in relation to planned results. Assess the management factors that contributed to the achievement of results in Phase II and whether project management and administrative resource allocations and processes, including financial, monitoring and reporting, are appropriate for the level of disbursements under the current and proposed projects.

Partnership

Examine the relationship between CIDA, CARE and other partner institutions/organizations (including MOH, CBOH, the DHMTs, CHPs, NHCs, etc.); identify strengths and weaknesses; and propose strategies for improvement as warranted. Assess the Government of Zambia's perception of the program and how this fits into the newly designed National Health Strategic Plan.

Lessons Learned

Identify development and operational lessons learned and provide recommendations for their utilization in the proposed follow up project design.

Exit Strategy

Identify and recommend simple, practical and cost effective strategies that CIDA and CARe Canada through the MWB Phase III Project can empower the target communities to sustain achievements after the Project has ended.

Stakeholder participation is fundamental to all CIDA evaluations. The Consultants are therefore required to conduct a review that provides meaningful involvement by all project partners, organizational and individual beneficiaries and other interested parties. Thus stakeholder participation should be factored into the design/planning, information collection, development of findings, reporting and results determination.

Appendix II Evaluation Framework

	Areas of Review	Key Questions	Sub-Questions
External Context	Political, Socio-Cultural, Economic, Donor and Stakeholder Contexts	What are the key threats and opportunities posed by the context for the MWB project in Zambia?	To what extent do the policies and activities of the GRZ regarding primary health care service delivery (at the national, provincial, district and /or local levels) providing an enabling environment for the project? To what extent do norms, values and attitudes in Zambia towards community and child health at the present time support the project's objectives? To what extent do the current economic conditions in Zambia (more specifically in the locations where the project operates) support or inhibit the project's implementation and allow for sustainability? To what extent do various donor and stakeholder priorities related to strengthening primary health care complement the investments made in this project? To what extent is the project linked to the National PRSP process, the National Health Strategic Plan and/or recent efforts to plan and implement health sector SWAPs in Zambia? To what extent does the stakeholder context (including project beneficiaries, the health care system and NGOs offering health-related programs/services) provide an enabling context for the project? What are the changes that are happening or likely to happen within the donor context that affect the sustainability or relevance of project results?
Internal Context	CIDA	What is the current programming and policy context for CIDA and what are the implications for the project as well as future phases?	What are the existing CIDA programming priorities/policies related to primary health care in Zambia? How do they support or hinder the current project? What has been CIDA's previous or parallel experience of programming related to support for PHC services in under-resourced areas of Zambia? What are some of the issues and risks related to support for PHC from CIDA's perspective?
	CARE	What is the current programming capacity in CARE Canada and CARE Zambia and what are the implications for the project as well as future phases?	To what extent do existing programming priorities of Canada Canada/Zambia support the project? What programming skills, knowledge and changes (current and potential) within CARE Canada/Zambia could affect the project and future phases, either positively or negatively? Is there sufficient management and analytical capacity in CARE Canada/Zambia to implement a large-scale investment such as the proposed next phase of the project?
	Zambian Project Partners	What is the current programming and policy context for key government project partners (e.g. MoH at national and district levels) and what are the implications for the project as well as future phases?	To what extent do the priorities, conditions and/or capacities of the Zambian MoH provide any risks or benefits for the project currently or in future phases? What key issues or factors at the district level that affect the project currently or in future phases? E.g. human resource capacity, management capacities, socio-economic issues, funding issues, political issues etc.?

	Areas of Review	Key Questions	Sub-Questions
Results Achievement	Results Achievement	To what extent is the implementation of the project in line with approved project plans (e.g. the LFA and WBS), and to what extent is the project achieving its planned outcomes and outputs?	To what extent are the planned outputs and outcomes being achieved to date or are likely to be achieved by the end of the project (based on analysis of cumulative progress)? What variances between planned and actual results have been noted? Are planned results clearly formulated, measurable and well-understood by all project stakeholders? Have the most effective short-term strategies (inputs and outputs) been utilized to contribute to longer-term outcome achievement? Specific areas to investigate under each key WBS (development outcome area) may include -- WBS 100: Verify evidence that health-seeking knowledge and behaviour has in fact increased among caretakers, and assess quality, appropriateness snd sustainability of outreach and education strategies used to increase caretaker knowledge WBS 200: Verify evidence that IMCI knowledge and services have improved among key stakeholder groups, that IMCI coverage has increased, and also assess the of quality of training provided as well as quality, scope and sustainability of services offered and degree of clinic, community and district support WBS 300: Verify evidence that ability to sustain and manage IMCI programming is in place at clinic and district levels, including quality and sustainability of drug procurement, HMIS use, strategic planning, budgeting and long-term management WBS 400: Verify evidence that knowledge of HIV/AIDS has increased among key groups and that these issues have been adequately integrated into IMCI services, including quality and sustainability of education and outreach WBS 500: Verify evidence that the project has supported effective use of M&E systems and tools for IMCI that are fully sustainable within the current health system, and linked to HMIS requirements To what extent have lessons and recommendations from previous phases been taken into consideration to improve the delivery of the project and help achieve project results?
Key Success Factors	Relevance	Does the project make sense in terms of the context, needs, priorities or problems that it is intended to address at different levels? Is the proposed next phase also relevant in terms of these same issues?	To what extent has the technical and material support provided by the project to date been consistent with the needs & priorities of the population served and the GRZ? To what extent has the technical and material support provided by the project been consistent with CIDA's priorities, including crosscutting issues? To what extent has the project support been consistent with the efforts of local organizations, the GRZ and other donors/agencies addressing PHC and IMCI in Zambia? To what extent does the GRZ value this project and see it as an important contribution to national priorities? Have appropriate and regular channels of dialogue and collaboration been established with the GRZ at different levels to maximize results achievement? Does the project provide technical assistance in an appropriate manner that complements Ministry of Health objectives and strategies?

	Areas of Review	Key Questions	Sub-Questions
Key Success Factors	Sustainability	Are there sufficient resources committed to maintain benefits/results of the project after the end of the current CIDA funding cycle as well as future projects? Will implementing partners have sufficient management and financial capacity to continue these initiatives? Are the partners effectively preparing the exit strategy for the withdrawal of CIDA support at some point in future?	To what extent is there local ownership for IMCI activities in district and community structures (including commitment to the planned results & the methods needed to achieve them)? To what extent is there a commitment of sufficient resources at the partner level to maintain benefits/results once specific sites or clinics graduate from project support (either during this project or in future phases)? To what extent is there adequate institutional capacity and commitment to maintain IMCI activities and results over time at the national, district and/or community levels? To what extent are domestic policies and the institutional environment conducive to long term maintenance of results? How is the critical issue of sustainability being addressed within the project? What specific strategies are being used by CARE Zambia to increase sustainability as well as organizational capacity of partners and help them ensure adequate long-term funding support?
	Partnership	Is there a shared responsibility and accountability for the project results among the key project partners and stakeholders? How well does the implementation partnership between CARE Canada and CARE Zambia function? Has the project mobilized the appropriate/optimal partners at different levels? Are the relationships with CIDA, other donors or stakeholders effective and efficient?	To what extent has there been active participation of local partners and beneficiaries in overall project design, implementation and monitoring? To what extent are there clear definitions, understanding & acceptance of the roles & responsibilities of various project participants? To what extent do project managers and partners have the appropriate tools they need to make decisions and take action? What new partnerships were developed to help achieve results? What have been the benefits and issues of the relationship between CARE Canada and CARE Zambia? Have there been any relevant changes in project management and implementation that have affected the relationship? What is the level of knowledge concerning the project among health sector stakeholders in Zambia (government, civil society, other donors)? How does the project link to other IMCI programming and/or health sector reform initiatives in Zamba? Has the project identified and selected the most strategic partners through whom the project's approaches can become widespread and replicated throughout Zambia? What has been done to improve knowledge about and adoption of IMCI among a wider partner base? How can the projet develop more effective and efficient partnerships at the local, national, regional and international levels in future phases, in order to support project implementation and results? How are lines of communication, accountabilities and funding demarcated among the various stakeholders and partners that CARE works with to implement the project?

	Areas of Review	Key Questions	Sub-Questions
Key Success Factors	Appropriateness of Design	Is the current project design appropriate and based on sound understanding of local context for the successful realization of the project results? Is the proposed design for the future phase based on sound analysis and likely to lead to sustainability of results? Is the design for the proposed next project phase properly focused?	To what extent are the current project goals, objectives, results and performance indicators aligned with CIDA's standards for results management? Were they defined using participatory approaches, and are they based on a sound understanding of Zambia's context and needs? To what extent have project activities been designed to effectively respond to the conditions, needs or problems identified with regards to implementing IMCI in Zambia? Have innovative ideas and approaches have been used to achieve results? To what extent have project risks been identified, monitored and action taken to mitigate them? Is the project monitoring system efficient and effective in tracking changes and progress towards results? How has it been linked to broader health system measurement to increase efficiencies? To what extent have lessons and innovations been recorded, reported on & disseminated to partners, the GRZ, donors and others involved in IMCI programming? To what extent is the current project appropriately designed to achieve its fundamental objectives? Is the proposed future phase appropriately designed in terms of results, targets and strategies for roll-out and graduation of clinics/sites? Are the current LFA and WBS appropriate for the current project? Are they appropriately designed for the proposed next phase? Are applied research activities contributing in real and meaningful ways to the achievement of project results? Is the current project working in areas that could be effectively implemented by others? Is the leadership of the project providing the guidance required to ensure effective implementation? How do these issues apply to the proposed new phase?
	Cost-Effectiveness of Results and Appropriateness of Resource Utilization	Are human and material resources used well in the current project? In general, are the project operational and management practices appropriate, efficient and cost-effective? For the proposed next phase, to what extent are appropriate resource utilization and management practices in place?	Are project staffing strategies appropriate and transparent? Are project personnel hired on the basis of merit (experience, capacity, knowledge)? How are human and material resources coordinated to achieve project results? To what extent does CARE Zambia as an organization have the operational and management capacity to deliver upon expected project results, especially for the next phase? • Is the organization properly staffed and funded? • Are personnel properly qualified and trained? • Are roles and responsibilities clearly defined and understood? • Is the number of project staff appropriate? Over the life of the current project, to what extent have the management and operations of the project conformed to or strayed from project approvals? Overall, to what extent the resources allocated (human and financial) between activities are appropriately focused to achieve expected results? Is this the case in the proposed next phase?

	Areas of Review	Key Questions	Sub-Questions
Cross-Cutting Issues	Gender Equality	Has the current project incorporated a gender equality approach towards implementation? To what extent does the proposed next phase of the project incorporate a gender analysis into plans and strategies?	What strategies has the current project put in place to promote gender equality? How effective are these strategies? To what extent have specific gender equality strategies or initiatives contributed to achievement of project results? What is the proposed gender equality approach for the next phase? Is it likely to be helpful in strengthening gender analysis and promoting improved gender equality at the organizational and/or community levels?
Recommendations, Lesons Learned and Future Design Considerations	Lessons Learned	What areas of improvement would have been desirable to enhance the overall performance of the current project?	What have been the major enabling and inhibiting factors that have affected success of the current project?
	Future Design Considerations	For the design of current next phase of the project, what are the main programming and operational improvements that should be made to enhance future performance and sustainability?	What changes in programming and/or operations should be considered (if any) to improve the project's performance in its next phase? What should be the scope, reach and size of the next phase, given the context and the capacities of partners and the CEA? How should key changes (if any) be integrated into the next phase proposal to CIDA?

Appendix III Mission Schedule

DAY	DATE	DETAILS
Mon	Jan 16	Team Leader arrives Lusaka
Tues-Wed-Thurs	Jan 17-18-19	Briefing meetings with CIDA and CARE Zambia
		Joint evaluation planning meetings with local Health Specialist and the PSU
		Finalize mission schedule and logistics with CARE Zambia and CIDA
Fri	Jan 20	Briefing meetings and interviews with CARE Zambia
Sat	Jan 21	Document review and research preparation
Sun	Jan 22	Travel to Kasama, Northern Province (nine hour drive)
Mon	Jan 23	Meetings/interviews with CARE staff and DHMT in Kasama.
		Project site visits, Kasama District.
Tues	Jan 24	Project site visits, Kasama District
		Debriefing with CARE project staff.
Wed	Jan 25	Travel to Ndola, Copperbelt Province (seven hour drive)
Thurs	Jan 26	Meetings/interviews with CARE staff and DHMT in Ndola.
		Project site visits, Ndola District.
Fri	Jan 27	Project site visits, Ndola District.
		Debriefing with CARE project staff.
		Return to Lusaka (three hour drive)
Sat	Jan 28	Data analysis
Sun	Jan 29	Free day
Mon	Jan 30	Meetings and interviews with donor community and GRZ stakeholders
Tues	Jan 31	Meetings/interviews with CARE staff and DHMT in Lusaka.
		Project site visits, Lusaka District.
		Joint data analysis by Team Leader and local Health Specialist
Wed	Feb 1	Evaluation debriefing meeting and presentation on initial findings with CIDA and CARE Zambia
		Team Leader departs Lusaka

Appendix IV Evaluation Participants

AFFILIATION	NAME	ROLE
CIDA Gatineau	Likezo Karn	Project Team Leader
	Jenny Hill	Junior Development Officer
	Michel Leblanc	Program Manager, Zambia
CARE Canada	Jessica Tomlin	Program Manager, Southern Africa
	Michelle Munro	Health and HIV-AIDS Specialist
	Kathleen O'Brien	Program Director, Southern Africa
	Mohammed Elmi	Finance Manager
	Viktoria Tsoy	Finance Officer
CIDA Lusaka/PSU	John Deyell	Canadian High Commissioner, Zambia
	Pierre Paul Perron	Head of Aid, Canadian High Commission
	Opa Kapijimpanga	Program Support Unit Director
	Alison Nabugwere	Health Specialist, PSU
CARE Zambia	Mark Vander Vort	Country Director
	Steve Power	Assistant Country Director
	Lazarus Sinyinza	Finance Director
	Nancy Drost	Organizational Learning Unit Director
	Martha Mwendafilumba	MWB Project Manager
	Daniel Kanyembe	MWB M&E Officer
	Maureen Mubanga	Former MWB Project Manager
	Fred Njobvu	MWB Clinical Coordinator - Lusaka
	Helen Chingulu	MWB Assistant Project Manager - Kasama
	Lawrence Banda	MWB Clinical Coordinator - Kasama
	Fidelis Mutolo	MWB Health Promotion Coord - Kasama
	[Vacant position]	MWB Assistant Project Manager - Ndola
	Mrs. Mary Sitchula	MWB Clinical Coordinator - Ndola
	Monica Myla	MWB Health Promotion Coord - Ndola
Zambia Ministry of Health (MOH) at National, Provincial and District Levels, including Central Board of Health	Dr. Mukonka	MOH/CBOH – Director Public Health and Research
	Dr. Tambatamba	MOH/CBOH – Child Health Specialist/Child Health Unit
	Mrs. M. Siame	MOH – Coordinator, UCI Secretariat and National IMCI Focal Point
	Mrs. Mtonga	MOH – Asst Coord, UCI Secretariat
	Chaswe Mwelwa	Clinical Care Specialist, PHO Copperbelt Province
	Mrs Mugala	Clinical Care Specialist, PHO Northern Province
	Mr. Bweupe	IMCI Focal Person, PHO Northern Province

AFFILIATION	NAME	ROLE
Other Zambian agencies	Ms. Chisela Kaliwile	National Food and Nutrition Commission (NFNC)
District Health Management Teams	Dr. Mbwili Muleya	Manager Planning and Development, Lusaka
	Mrs. Mary Banda	District IMCI Focal Person, Lusaka
	Dr. Nyendwa	Manager Planning and Development, Ndola
	Racheal Simutowe	District IMCI Focal Person, Ndola
	Florence Ngulube	Manager Planning and Development, Kasama
	Mrs. Lissa Busiku	District IMCI Focal Person, Kasama
	Mrs. G. Nanyinza	District Director of Health, Mungwi (potential expansion site)
	Mr. Mutale	Manager Planning and Development, Mungwi (potential expansion site)
Clinics and Communities – including Clinic Administrators, Health Workers and Supervisors, NHC Members, Volunteers and Community Members/Beneficiaries etc	Elicah Kamiji, I/C Ireen Nyirenda – IMCI FP Davison Chibilika – NHC Robert Banda – CHP	Matero ref clinic (Lusaka District)
	Mrs. Michelo – I/C Paul Phiri – CHP	Kaunda Square clinic (Lusaka District)
	Astridah Chibale – I/C Ruth Mwale – IMCI FP Evans Chikamba - NHC/CHP Various NHC members/CHPs	Kavu clinic (Ndola District)
	Judith Kalezu – I/C Esthelle Zulu – IMCI FP Calisto Chota – NHC/CHP Various CHPs	Bwafwano clinic (Ndola District)
	Ward Chiponya – Traditional Healder/CHP	Twapia clinic (Ndola District)
	Ireen Kapekele – I/C Lydia :Mwalongo – IMCI FP Brown Kangwa – NHC/CHP	Milima clinic (Kasama District)
	Gabriel Njobvu – I/C Beauty Maluti – IMCI FP Joseph Mumbi – NHC/CHP	Location clinic (Kasama District)
	Leonard Musonda – I/C Peter Mulenga – NHC/CHP	Chiombo clinic (Kasama District)
	Mr. Mulenga Chaponta – Traditional Healer/CHP	Lukasha Clinic (Kasama District)
Selected Health Sector NGOs, Donors and/or International Agencies	Maria Skarphedinsdottir	Human Development Advisor, DFID
	Dr. Lastone Chitembo	C-IMCI Coordinator, Health Services and Systems Program (HSSP), USAID
	Dr. Kasonde Mwinga	Child and Adolescent Health Advisor, WHO

AFFILIATION	NAME	ROLE
	Flint Zulu	EPI Officer, UNIFEF
	Rodgers K. Mwale	Project Officer, Malaria Control, UNICEF
	Ms. Komiko Igarashi	Nutrition Promotion Expert, JICA
	Ms. Yorin Kim	Community Health Expert, JICA

Appendix V List of Documents

PROJECT DOCUMENTS
• PAD -- March 26th, 2001
• Contribution Agreement with approved budget -- August 8th, 2001, no-cost extension amendment Oct 20th, 2005
• Project Implementation Plan -- November 2001
• Annual Workplans (2001-2005)
• Semi-Annual Narrative and Financial Reports (2001-2005)
• Project Surveys (2003-2005)
• Project Steering Committee Meeting Minutes and Notes
• Preliminary Proposal Phase III November 2005
• Miscellaneous Power Point presentations used to summarize project results
• Report on the Monitoring Tour of Moyo Wa Bana IMCI CARE Project, May/June 2003 (CIDA-PSU)
GOVERNMENT OF ZAMBIA DOCUMENTS
• Health Care Financing in Zambia: A Study of the Possible Policy Options for Implementation (University of Zambia, Ministry of Health, Central Board of Health and WHO, June 2005)
• National Health Strategic Plan 2006-2011
• Child Health Policy 2006 (draft)
• Child Health Situation in Zambia (2005)
• National Strategic Plan for Child Health in the Community 2005-2009
• IMCI Orientation and Planning Guidelines for Provinces and Districts 2005
• IMCI National Strategy 2004-2006
• IMCI National Health Facility Survey 2001
• Selected District Action Plans (Ndola, Lusaka, Kasama and Mungwi Districts)
• Miscellaneous other planning, policy and budgetary documents as required
OTHER REFERENCE DOCUMENTS
• Health Policy and Planning : A Journal on Health in Development, « The multi-country evaluation of Integrated Management of Childhood Illnesses (IMCI) effectiveness, cost and impact », Volume 20 (Supplement 51), December 2005
• Miscellaneous internet resource documents from WHO, UNICEF and other agencies

Appendix VI Comments on Draft MWB Proposal to CIDA

Originally submitted to CIDA February 15th, 2006

1. Introductory Notes

- The current Preliminary Proposal was submitted to CIDA in November 2005.
- During and immediately following the MWB II project evaluation field mission, which took place from Jan 16th – Feb 1st, 2006, the evaluator agreed to prepare a short memo detailing her comments on the Preliminary Proposal, and submit it to CIDA and CARE in advance of the full draft evaluation report (to be available by March 10th, 2006). Some of the key issues and observations contained in verbal evaluation debriefings to CIDA and CARE were incorporated into these comments. Some revisions to the proposal may already have started to take place based on what was discussed.
- The Preliminary Proposal is understood to be a 'working draft' or a work-in-progress, in response to early discussions between CIDA and CARE regarding a possible extension to the current MWB project.
- There was no budget attached to the version of the Preliminary Proposal provided to the evaluator for comments. Therefore, no comments are included on the proposed budget.
- The Overview section which follows provides a brief synthesis of the main points and observations from the evaluation debriefings that may influence the proposal redesign. Other detailed comments are organized according to each section of the Preliminary Proposal.

2. Overview of the Proposal

- As already discussed during the evaluation debriefings, MWB Phase III should be redesigned so that it clearly addresses the need to strengthen the ability of the GRZ/MoH to take full control of IMCI roll-out and sustainability in future.
- There is a need to increase the leverage and sustainability of any further CIDA funding for IMCI by finding strategic ways to combine project-level support through CARE, with direct investment by CIDA in district basket funds earmarked for child health and/or other health sector investments. The project itself should find ways to directly address institutional capacity building requirements at the provincial and/or district level, in order to further increase ownership/management, quality assurance, and resource allocation for on-going IMCI programming.
- The scale-up strategy for IMCI found in the Preliminary Proposal can be partly justified on humanitarian grounds, given the pressing need to address child health issues in Zambia and contribute to achievement of MDG #4. However, such a strategy runs the risk of fostering the dependency of the MoH on external project support as a service substitution mechanism in key programming areas such as child health. The Preliminary Proposal must demonstrate clearly that long-term issues related to policy development, ownership, institutional development and financial commitment for IMCI are addressed in meaningful ways by the project, whether directly or indirectly.

3. Background/Context (Section 1.1):

- The Context section will obviously need to be updated based on what has happened since the draft proposal was prepared in 2005. Given that the health sector context is evolving quite rapidly, it will be useful to consult closely with the PSU health specialist in Lusaka to ensure that the most up-to-date information is included in terms of evolving policies, trends and issues.
- Overall, the Context section should address the following points that need to be discussed further with CIDA: What are the pros and cons of project versus basket funding, or some combination, within this context? Given that restructuring of the MoH and CBOH is still on-going, is this likely to affect the proposed project in any way? What is the impact of the new national budget (released Feb 3, 2006) on funding for the health sector, including allocation of funds to the district level to address child health issues? What are the opportunities for leverage and synergy with other CIDA-funded initiatives in the health sector (e.g. support for human resource development, strengthening drug procurement systems and health research to support evidence-based policy development)? The linkages between the project and the current National Health Strategic Plan, the National Child Health Policy and the national IMCI Strategy/Action Plan need to be described in detail. Some information provided in Section 4 on alignment with GRZ priorities could be moved to this section.

4. Rationale (Section 1.2):

- The child survival statistics are very compelling in terms of the need to continue to directly support child health interventions in Zambia. However, they also clearly indicate that this may be a very difficult situation to turn around in a short timeframe, as the contextual factors are so complex and potentially disabling. The various risks related to programming in this area need to be elaborated on fully in Section 2.8 (see notes below).
- The literature citing information on IMCI utilization in Africa and globally could be examined in more detail. For example, CARE Canada has already flagged the recently published WHO evaluation on IMCI as being an important source of information about what has been learned (see Health Policy and Planning, Volume 20, December 2005). It would be useful to highlight in more detail some of the main issues (positive and negative) raised in the WHO evaluation in relation to the strategy planned to expand IMCI in Zambia. Would it be feasible for CARE to utilize any of the Zambian researchers on this evaluation to provide further technical input on the MWB proposal?
- The list of the various enabling factors for continued IMCI support at the end of the rationale sector is useful. However, more detail could be provided on how each of these would likely influence further programming on IMCI.

5. Project Description (Section 2):

- The description of the linkages to the MDGs in the preamble to this section should probably be placed somewhere in Section 1 of the proposal instead of here.
- Note that main impact indicator provided in terms of measuring progress towards MDG #4 needs to analyzed at some stage in the proposal in terms of the realistic benchmarks for progress. How realistic are the prospects of achieving the target provided in the indicator during the given timeframe? (Note that the timeframe is actually between 2000 and 2015.) Given that work on IMCI in Zambia began in the year 1995 and that we are now in 2006, is there any data to suggest that child mortality has started to decline at all over the last 10 years as a result of these interventions, in contrast to the broader child health trends at the national level as outlined in Section 1.2? If not, then what are the realistic prospects for progress in the next five years? Ten years? What specific aspect of this is the project hoping to support?

6. Expected Results (Section 2.1):

- See comments below on Appendix I, where there is a detailed analysis of each level of the results framework.

7. Approach to enhancing project reach (Section 2.2):

- Not all of the so-called 'lessons' provided in this section can really be seen as 'lessons' in a programmatic sense, as some of them are actually related to the contextual analysis provided in Section 1. It is important to keep in mind that a 'lesson' is a specific observation (either positive or negative, developmental or operational) that can generalized and then reapplied or replicated to improve future performance. The information in this section also provides more details on the factors in the health sector context that are likely to affect MWB III, both positive and negative, and could be used to 'beef up' the risk analysis found in Section 2.8.
- The core concept behind MWB III is that the reach will be expanded in terms of extending IMCI coverage to a much larger proportion of the Zambian population. Based on the contextual analysis, the argument is that this is achievable within the proposed timeframe. However, based on the preliminary observations from the evaluation, it appears that the reach will need to be scaled back somewhat to take into account the need to work at a more strategic level to support and enhance health sector reform and long-term program sustainability by the GRZ.
- In order to ensure that the proposed reach is achievable, it will be important for the project to attempt to distinguish more clearly between 'direct' and 'indirect' beneficiaries. This needs to be linked to the analysis of the results logic (see Annex I below). The design found in the Preliminary Proposal is targeting a very large group of direct beneficiaries (both communities and institutions). The onus is on CARE to demonstrate clearly that this approach would be achievable and realistic, given all the risk factors. While there is evidence that the community-based IMCI approach yields observable and measurable direct benefits with certain key groups, it has also emphasized the risks and challenges of trying to carry out IMCI on the government's behalf. In this sense, the present proposal is probably too wide in its proposed scope (in terms of the extent of geographic and population coverage across the country).
- As suggested in the post-evaluation debriefing meetings, it will probably be more feasible to focus within a narrower geographic focus, e.g. ensure handover and replication in existing districts/provinces, then expand to two-three more provinces/districts to demonstrate and document how this process of full IMCI roll-out and support can in turn be replicated by the GRZ itself (in combination with some basket funds from donors at the district level that could be leveraged to help fund this process). Major focal areas might include: 1) developing and implementing a process for rapid graduation of existing sites; 2) developing and implementing a process for rapid handover of full IMCI management to DHMTs for existing sites, via more intensive management and technical support at the district and/or provincial levels; 3) providing pilot opportunities for districts themselves to replicate or expand IMCI roll-out to new sites using the CARE model, testing options and designing feasible approaches, under CARE guidance and technical support; and 4) providing pilot opportunities for provinces to coordinate and manage district-to-district transfer and replication/scale-up of IMCI.

8. Achieving results: lessons guiding improved approaches (Section 2.3):

- Again, not all the 'lessons' presented in this section are clearly formulated as lessons. Many 'lessons' simply describe some of the strategies used in MWB Phase II, and indicate how they will be reapplied in Phase III. Some possible lessons related to weaknesses in the capacity building approach previously used with districts are not included at all.

- If extensive revisions are made to the LFA as suggested in the comments on Section 2.2 and the analysis of Annex I below, then it will be necessary to rewrite this section completely.
- The purpose of such a descriptive section in the revised proposal should be to present in detail under each Outcome area, the strategy and package of inputs, deliverables and outputs that will be used to achieve medium-term development results. For every Outcome, the corresponding WBS packages should be analyzed in detail to demonstrate that they have been carefully designed to support Outcome achievement.

9. Cross-cutting themes (Section 2.4)

- For integration of HIV-AIDS into IMCI, it would appear to be most useful to focus mainly on ensuring that the new HIV-AIDS module is implemented as part of IMCI case screening. This is mentioned elsewhere in the proposal but the strategy for ensuring this takes place should be elaborated on here. Mainstreaming of HIV-AIDS for health workers and volunteers is another strong strategy, but more details need to be provided here on how this can be achieved.
- The project's own analysis is that not much was done on gender issues in the current phase. Ideally, the new phase should incorporate a gender strategy prepared by a local gender consultant who can be used to monitor and advise on on-going work in this area. An outline of the elements that could be included in a project gender strategy, as well as the approach to preparing the gender strategy, should be included in the proposal.

10. Management strategy (Section 2.5)

- More details should be provided in this section on how the next phase of the project proposes to create effective, strategic linkages at a central policy level through existing health sector committees and working groups related to child health (in conjunction with CIDA). The role of the PSC should ideally be enhanced to provide a forum for fostering institutional commitment to plan and manage child health programming. It is possible that some of this analysis could be combined with what is found in Section 4.
- More details are required here about the management and accountability linkages between CARE Canada and CARE Zambia. All positions and roles should be shown on an organizational chart, accompanied by short descriptions of their responsibilities, technical requirements and skills (in order to justify their level of effort). Reporting, monitoring and communications links need to be clearly depicted, including linkages within the CARE Zambia organizational structure in particular related to potential support from the health sector specialist and other potential input from the OLU on results management and measurement.
- See additional comments under Section 3 below.

11. Measuring success (Section 2.6)

- The project needs to measure change in several key areas to show that: a) the IMCI strategy as implemented by the project is really making a difference in terms of improving child mortality/morbidity, health delivery procedures, health seeking behaviours and health system efficiency; b) that institutions and groups responsible for sustaining IMCI are capable of continuing to maintain and measure these trends over time, and use the information for evidence-based policy, advocacy and programming; and c) the institutions and groups responsible for sustaining IMCI have the systems, tools, expertise and functions in place to maintain and expand IMCI over time without sacrificing quality, coverage or efficiency.

- For a) above, it may not in fact be feasible to measure all four areas listed in a comprehensive way via the project itself. The description does indicate that the project will try to use other available data to measure IMCI progress, without resorting to primary data collection.
- The project's stategy of using annual household surveys and monthly community reports to track key health status and disease burden changes is a commendable one, and if simplified from the previous phase could still be a useful tool for measuring what concrete difference IMCI is making. However, the risk is that the project does not find ways to ensure that key partners can continue to do this for themselves in the long term, through institutionalizing such performance measurement strategies. There appear to be several instances from the previous phase where the project has supported collection of extensive data that either is not being used properly by key partners and/or is unlikely to be continued in the absence of the project. Conversely, districts have also been shown to be somewhat dependent on data generated by the previous phase of the project to track their own performance in key areas. It would be useful to include more concrete information in this section regarding how the performance measurement system for the project will complement and reinforce health monitoring systems at the clinic, district, provincial and (possibly) national levels.
- It is a good strategy to link the baseline for new areas to the next ZDHS (which should take place in 2006), rather than having the project conduct its own independent baseline survey.
- Another aspect of measurement that needs to be incorporated into this section is how project performance data will be analyzed, by whom and at what levels.
- The proposed indicators are relatively strong and greatly simplified from the previous phase, but they will need to be adjusted once the project design is revamped as suggested elsewhere in these comments, and then refined further during the PIP stage.

12. Engaging Canadians (Section 2.7)

- Engaging both Canadians and the international community could be further strengthened by incorporating an explicit operational research and dissemination strategy and results area into the proposed project.
- This could also be further strengthened via linkages with Canadian research institutions such as IDRC and Canadian and international universities.

13. Risk analysis and mitigation strategies (Section 2.8)

- This risk analysis provided here is far from complete and appears to be over-simplified. Some aspects of this have already been mentioned in the comments above. As well, some risks appear to be under rated, e.g. those related to economic deterioration, the GRZ's financial commitment to IMCI and the ability of PHOs and DHMTs to manage IMCI. There is no mention of the risks related to low human resource capacity in the health sector, nor of the many competing priorities for health funding.
- Ideally, the risk analysis should be linked more explicitly to the results framework for the project, and to the assumptions listed in the LFA. The risk analysis should be sufficiently detailed so that it forms the basis for a future management and monitoring tool by the project and its partners. More contextual risk analysis from Section 2.2 could also be included here.

14. Sustainability strategies (Section 2.9)

- The analysis provided in this section appears to be over-optimistic given the many issues and potential challenges to sustainability identified during the Phase II evaluation. For example, even though the phase-out process with the DHMTs and clinics was not successfully completed in the

previous phase, a similar procedure is included here. Based on past experience, this may not be realistic.

- The different strategies for working at the provincial and district levels to achieve sustainability for on-going IMCI programming and institutionalization of IMCI support, need to be described more clearly. Perhaps some form of institutional capacity and performance assessment process with the provinces and/or districts could be used to help determine both capacity development requirements/gaps and the degree of progress achieved towards full ownership and sustainability of IMCI over time, based on past experience.
- As noted during the Phase II evaluation, full ownership and management of IMCI by DHMTs will require some form of organizational change within district health structures. As well, districts may need technical assistance in creating realistic budgets and plans for IMCI that accurately reflect all aspects of programming, supervision, quality assurance and technical follow-up (not just training delivery). More details on these areas of work need to be included in the proposal, and incorporated into the results framework.
- Another area for sustainability that needs to be taken into consideration is the role of the Child Health Unit in the central ministry. It is difficult to say if the project can directly influence capacity, ownership and organizational effectiveness at this level, however this situation will obviously affect district-level sustainability to some extent. This aspect of the context needs to be fully analyzed in Section 1, and then taken into consideration when defining sustainability strategies.

15. CARE Canada and CARE Zambia (Section 3)

- Some of the information found here related to the management and cooperation relationship between the two agencies could be relocated to Section 2.5, as noted above.
- In terms of presenting the project proponents, information is lacking in this section regarding the ability of both CARE Canada and CARE Zambia to not only implement community-based health services, but also to build capacity of local government agencies. It would be useful to indicate more clearly what expertise can be brought to this area, both in Zambia and elsewhere. For example, the local governance capacity building project implemented by CARE Zambia may be a useful example of project-based support for strengthening decentralized management and implementation systems. As well, it would be useful to spell out how synergies could be built between these types of projects and the proposed Phase III.

16. Coherence with CIDA and Zambian priorities (Section 4)

- This section including the sub-sections should be integrated with Section 1 and/or Section 2.5 if possible. The linkages with CIDA's overall health sector strategy in Zambia need to be explored and analyzed more fully, and the potential synergies between the project and the areas of central policy influence and support for basket funding need to be described.
- The sub-section on Relations with the GRZ points out the dependency of government on the project in terms of achieving programmatic results and measuring improvements in child health. This is not necessarily a positive selling point for the current proposal. The information here as well as in the subsequent sub-section on Partners needs to be strengthened to describe in more detail the coordination/accountability mechanisms and leverage opportunities that will be used to ensure full GRZ ownership over the project and its results. This information should be placed earlier in the proposal as the basis for understanding how the project will seek to build GRZ/MoH capacity and performance for child health programming.

17. Annex I: LFA

- Overall, the LFA or results framework for the project as proposed is rather weak. It does not present a very dynamic 'theory of change' and the results statements themselves are often poorly framed or incomplete. Neither does the draft LFA appear to capture all the potential activities and strategies referred to in the body of the proposal. Results statements need to specific clearly and precisely 1) what type of change is being created; and 2) with what specific target groups/institutions. If multiple target groups are lumped into one Outcome area, then it may be difficult to describe accurately the many different strategies or processes required to achieve change with different groups.
- As stated above, the project needs to be redesigned to take into account the need to create institutional change and ownership, in parallel with demonstrating and piloting processes for direct service delivery and community mobilization for IMCI. Institutional change is implied in the first Outcome statement but the exact type and scope of this change needs to be further defined and specified.
- In general, the causal linkages between Outputs and Outcomes are quite weak in the present results chain. In many cases, it appears unlikely that the Outputs specified under each Outcome are really sufficient to achieve the result as stated.
- It is highly recommended that CARE hold a series of multi-stakeholder discussions or planning workshops (facilitated by an internal or external RBM expert) to construct and critique a feasible results chain (i.e. working through the strategy and causal linkages from activities to impact), as the basis for a revised LFA.
- At the Impact level – The Impact and its indicators are coherently linked to national and international targets on child mortality and health. The project is of course NOT solely responsible for achieving this impact and meeting the indicator targets – accountability is shared among a wide range of stakeholders. In addition, the risk factors at the impact level appear to be very high given that the assumptions as stated are unlikely to hold true for the life of the project. As noted above, it is very important to highlight these risk factors elsewhere in the proposal, so that the GRZ, CIDA and CARE are fully aware that these targets may not be met.
- Outcome #1 – It is essential to improve the precision of this outcome statement, and/or to subdivide it into more precise sub-areas of work that are tailored to the three target institutions mentioned. The terms 'strengthened quality' and 'increased uptake' are quite vague and do not indicate clearly the type of organizational change required. Based on the ideas generated by the Phase II evaluation, the project needs to increase its focus on building institutional capacity and performance in the health sector, so that IMCI can be sustained over time by GRZ using health sector basket funds or other core resources in the health sector rather than relying on specific projects. This could be seen as the 'governance' component of the project, i.e. strengthening health sector management and accountability structures and functions in various institutions responsible for sustaining work on child health and IMCI. The institutional management skills and systems required are somewhat different (although interlinked) at the three different levels that are mentioned in this outcome statement (provincial, district and health facility). Plus, there is also the central level where the project may need to do advocacy for greater allocation of IMCI resources to the districts. Somehow, the proposal has to demonstrate that CARE has the capacity to work at all four of these levels simultaneously (as well as at the community level) in order to strengthen public health management and implementation, and that there is a distinct strategy and measurable results possible for each level. NOTE that the many contextual risks need to be carefully taken into account here when designing the results statements, given the various factors affecting the health sector.

- The outputs supporting Outcome #1 need to be refined if this outcome is changed as noted above. It might make sense to have dedicated WBS areas, each focused on the different institutional target organizations (e.g. PHO, DHMT, and clinics). It will be necessary to define what can be done for each target institution, not only in terms of training and inputs but also management skills, including supervisory, planning and financial allocation systems.
- Outcome #2 – This is stated in a vague way. Terms like 'enabled' should never be used in results statements, and need to be made much more precise in order to be measurable. What are the exact changes in behaviour, practice, knowledge, skills or systems that are being proposed? Who are the 'targets of change' for this outcome -- families, caretakers, CBAs? In certain targeted areas or all over the country? The main problem with this outcome is that it implies a much wider direct effect at the community level for the project itself than may be feasible. It implies that the project can and should produce the kind of broad-scale change in societal behaviour that can only be brought about by the institutions and citizens of Zambia themselves. This makes it read more like an impact statement. It is obviously interlinked with Outcome #1 because improved institutional performance and capacity can also lead to stronger knowledge and action at the community level. Could the project be selective about how it scales up IMCI via selected demonstration sites or districts to show not only how the community component of IMCI can work effectively, but also how the process of community education, mobilization and empowerment can be further replicated and supported by the various government institutions as stated under Outcome #1? More thinking needs to go into the degree to which the project can or should work directly at the community level, versus empowering and coaching key Zambia institutions to do this work themselves. The creation of a demand-driven and community-based model for child health is obviously quite important and the project already has valuable knowledge in this area. However, this component of the project could easily receive the most attention, so it needs to be balanced with the systems/governance component in terms of focus.
- The supporting Outputs for Outcome #2 also need to be revamped depending on the focus chosen. Improved participation/knowledge (Output 2.1), access to services (Output 2.2) and access to essential commodities (Output 2.3) are obviously key components of a community-driven approach to child health. The existing project has already demonstrated that these tools, methods, systems and inputs can mobilize the community, the question is, how can they be replicated and sustained over time? What other short-term results are required to make sure that this takes place?
- Outcome #3 – If HIV-AIDS and gender issues need to be mainstreamed into IMCI delivery, then perhaps they should be integrated into the other outcome areas rather than treated as a separate outcome. Again, the key question is how to institutionalize these approaches at the province, district, clinic and community levels. For HIV-AIDS, planning, capacity building and monitoring at the district and clinic levels for the new SHI component of IMCI case management could be added as an output linked to Outcome #1, as well as at the community level under Outcome #2. For gender, the types of gender analysis skills required for the different institutions and for the community need to be more clearly defined, and included under each outcome. 'Greater appreciation' of gender issues (Output 3.3) does not state clearly the type of change required or with whom, and is therefore not a feasible results statement.