ACKNOWLEDGEMENT

We would like to give special thanks to everyone who made this process evaluation possible.

Particularly, we would like to thank the respondents who participated in the survey and allowed us to collect data from them. This includes staff at Zimba District Health Office, Kamanga Rural Health Post, Chalimongela Rural Heal Post and On Call Africa (staff and volunteers). We would also like to thank the community volunteers in the two communities we visited in Zambia for their participation. Finally, we wish to acknowledge all the logistical support that we got from the OCA staff which made it possible for us to conduct the evaluation within the limited time frame we had.

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### ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>CBV</td>
<td>Community Based Volunteer</td>
</tr>
<tr>
<td>CHA</td>
<td>Community Health Assistant</td>
</tr>
<tr>
<td>CHU</td>
<td>Community Health Unit</td>
</tr>
<tr>
<td>CLTS</td>
<td>Community-led Total Sanitation</td>
</tr>
<tr>
<td>CO</td>
<td>Clinical Officer</td>
</tr>
<tr>
<td>DHO</td>
<td>District Health Office</td>
</tr>
<tr>
<td>EHT</td>
<td>Environmental Health Technician</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
</tr>
<tr>
<td>HCF</td>
<td>Healthcare Facility</td>
</tr>
<tr>
<td>HFA</td>
<td>Health Facility Assessment</td>
</tr>
<tr>
<td>KII</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
</tr>
<tr>
<td>NHC</td>
<td>Neighbourhood Health Committee</td>
</tr>
<tr>
<td>OCA</td>
<td>On Call Africa</td>
</tr>
<tr>
<td>RHP</td>
<td>Rural Health Post</td>
</tr>
<tr>
<td>TOC</td>
<td>Theory of Change</td>
</tr>
<tr>
<td>WASH</td>
<td>Water, Sanitation and Hygiene</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

BACKGROUND: OCA has been working in collaboration with MOH Community Health Unit (CHU) to develop and implement a model Rural Health Service Package. This package builds on the existing standards for rural health facilities and explores interventions that could help address existing gaps in quality health service delivery at the Rural Health Post (RHP).

OBJECTIVES: The main objective of the process evaluation was to assess the performance of pilot activities implemented so far and the impact of the project on capacity of health facility staff and CLTS champions.

METHODOLOGY: A cross-section study design was implemented to conduct this process evaluation, collecting data at one point in time from relevant stakeholders. Primary data was collected through Key Informant Interviews (KII). Qualitative data was collected which sought to understand the perspectives and opinions of MOH, health facility staff, CLTS Champions, OCA staff and OCA volunteers on the OCA approach to health systems strengthening.

FINDINGS: The evaluation found that the project was performing very well so far, and all those involved in the project at different levels of the health system found the project to be very relevant and effective. The project was already showing positive impacts on improved quality of service delivery by the different staff involved in capacity building and behavior change on WASH practices among community members. Sustainability of project activities and expected better health outcomes were accounted for in the health systems approach the project is taking. Planned activities in infrastructure development and training are expected to continue to contribute to improved health outcomes if implemented as planned, even after the OCA project comes to an end.

In terms of effectiveness of project implementation and participation, the evaluation found that project implementation so far has been largely efficient. Two key challenges were observed with implementation efficiency, some delays in activity implementation and communication challenges among all partners involved in project implementation. As this is the beginning of the project implementation phase, it is expected that these identified challenges will be addressed as project implementation continues.

The Evaluation found that capacity building was impacting the staff positively. The staff reported improvements in the way they conducted their work both at the health facility and in the community. The capacity building had also led to improvements in the way community volunteers and health facility staff work together in delivering health services.

CONCLUSION: The evaluation found project implementation so far to be relevant and effective, with a sustainable approach. The project is already having positive impacts on staff capacity, improved outcomes and improved service delivery.
1.0 BACKGROUND

On Call Africa (OCA) has been supporting the Ministry of Health (MOH) to work towards their national strategic objective of designing a model rural health system. Through this process OCA has been working in collaboration with MOH Community Health Unit (CHU) to develop and implement a model Rural Health Service Package. This package builds on the existing standards for rural health facilities and explores interventions that could help address existing gaps in quality health service delivery at the Rural Health Post (RHP).

Through this project, OCA has supported Chalimongela and Kanyanga Rural Health Posts (RHPs) in the pilot phase to: conduct a Health Facility Assessment (HFA) aimed at prioritizing areas for quality improvement; develop quality improvement plans in the identified key priority areas; capacity build staff at the health facility and in the community to equip them to implement the quality improvement plans that have been developed; and implement various strategies aimed at improving service delivery and health outcomes. OCA has worked in close collaboration with Community Health Unit (CHU), District Health Office (DHO), health facility staff and community members to achieve health systems strengthening. Finally, OCA has delivered training to health workers and Community Led Total Sanitation (CLTS) Champions at the facilities to equip them to implement the quality improvement plans that have been developed. OCA hopes to improve access to quality health care by implementing activities and achieving outcomes outlined in the theory of change below.

Figure 1: OCA Approach Theory of Change
This process evaluation was conducted to build evidence that will be useful for scaling up this health systems strengthening approach to other RHPs and to ensure effective implementation of quality improvement plans over the next 18 months at the two RHPS where the pilot was being implemented. The evaluation was conducted with the aim of assessing the performance of the pilot phase in order to generate lessons learned from implementation so far, suggest areas of improvement and recommend effective strategies for achieving sustainable project outcomes and health systems strengthening. The Evaluation also assessed the impact of the project on the capacity of health workers and CLTS champions to deliver quality health services at the two facilities: Kanyanga Rural Health and Chalimongela RHPs.

1.0 OBJECTIVES

The main objective of the process evaluation was to assess the performance of pilot activities implemented so far and the impact of the project on capacity of health facility staff and CLTS champions. The evaluation assessed the relevance, effectiveness, efficiency, impact, sustainability, and level of community participation of project activities to achieve proposed outcomes and deliver quality health services. Specifically, the assignment achieved the following objectives:

i. Assessed project performance so far; whether the project’s proposed approach was aligned to the project’s overall expected outcomes and outputs as mapped out in the project’s Theory of Change (TOC) and the broader government expectations of a model rural health facility.
ii. Assessed the impact of the project on the capacity of health workers and CLTs Champions.
iii. Highlighted strengths and recommended areas of improvement of the quality improvement plans.
iv. Generated lessons learned from the project implementation process so far that will be useful for scale-up in future.

Findings of this evaluation have been used to generate lessons learned, highlighting strengths and weaknesses of the OCA approach and to identify areas of improvement for project implementation.

2.0 METHODOLOGY

2.1 RESEARCH DESIGN
A cross-section study design was implemented to conduct this process evaluation, collecting data at one point in time from relevant stakeholders. Primary data was collected through Key Informant Interviews (KII). Qualitative data was collected which sought to understand the perspectives and opinions of MOH, health facility staff, CLTS Champions, OCA staff and OCA volunteers on the OCA approach to health systems strengthening. Perspectives on staff capacity building and its impact on staff capabilities was also collected. Primary data collection was supported with an extensive desk review of project documents. Figure 2 summarizes the evaluation methodology implemented.
2.2 DESK REVIEW
An extensive desk review of project documents was conducted to develop an in-depth understanding of the OCA approach and activities implemented. The documents reviewed included; HCF assessments reports for Chalimongela and Kanyanga, RHSP theory of change with summaries of quality improvement plans for the two facilities, CLTS theory of change, CLTS concept note, results framework and the HCF assessment tool. The desk review deeply informed the development of the data collection tools which are provided in Annex 1.

2.3 INCEPTION MEETING
The evaluation team conducted an inception meeting with OCA staff on the evaluation objectives and research methodology. During this meeting, the data collection plan and study respondents were agreed upon. Purposive sampling was used to select survey respondents. This enabled the selection of respondents who have been involved in the project and would give sufficient information on project activities implemented so far.

2.4 TRAINING ENUMERATORS
The data collection team was comprised of two enumerators and one supervisor. Training of the data collection team was conducted over two days. The team was trained on the all the data collection tools by reviewing each question to foster a common understanding. Questions were also translated into Tonga and role plays conducted to allow enumerators to simulate how they would conduct the interviews during actual data collection.

2.5 DATA COLLECTION
Data collection was conducted from 15\textsuperscript{th} March 2022 to 22\textsuperscript{nd} March 2022. Two enumerators conducted in-person data collection at the DHO’s office in Zimba and at the two facilities, Kanyanga and
Chalimongela. The other KII’s were conducted virtually; either on mobile phone or on google meets. One interview at CHU was not conducted as there was need to seek administrative clearance and this could not be achieved due to time constraints for this evaluation. A total of 23 KII’s were conducted.

Table 1: Distribution of KII’s

<table>
<thead>
<tr>
<th>Method</th>
<th>Informant</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KII</td>
<td>District Health Office</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility</th>
<th>Chalimongela</th>
<th>Kanyanga</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>KII</td>
<td>In-charge</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>KII</td>
<td>Nurse</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>KII</td>
<td>EHT</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>KII</td>
<td>Clinical Officer</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>KII</td>
<td>CLTS Champions</td>
<td>3</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project Staff</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>KII</td>
<td>OCA staff</td>
<td>2</td>
</tr>
<tr>
<td>KII</td>
<td>OCA Volunteers</td>
<td>3</td>
</tr>
</tbody>
</table>

TOTAL activities 23

2.6 COVID-19 MEASURES
During in-person data collection, enumerators followed the MOH protocols with regards Covid-19 prevention measures. All respondents were provided with a mask to wear during interviews. Hand sanitizing and social distancing were also observed.

2.7 DATA QUALITY ASSURANCE
Data quality checks were conducted on both audios and transcripts. Once audios were uploaded, a sample was selected for quality assurance from each enumerator to provide feedback and ensure that they were collecting all the required information. A debrief session was conducted with the enumerators after they came back from data collection to capture their observations during data collection. Transcripts of audios were also checked for inconsistencies or errors. Any errors and inconsistencies were communicated to the transcribers for corrective action during debrief sessions.

2.8 DATA ANALYSIS AND TRIANGULATION OF RESULTS
We used a thematic method to analyze the data collected and triangulated the results with information from the desk review and our own observations during data collection. Transcripts were coded in Excel, after which the coded exerts were organized into themes for further analysis. Data analysis included a coding process in which consistency checks were conducted, appropriate variable names developed and finally themes were deduced arising from the data. Themes followed the key main objectives of the evaluation and information collected from the evaluation questions. Table 2 presents the evaluation matrix.
Table 2: Evaluation Matrix

<table>
<thead>
<tr>
<th>Objective</th>
<th>Analysis Theme</th>
<th>Key Evaluation Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project implementation</td>
<td>Assessment-identifying challenges and quality improvement</td>
<td>Describe to me the process of how you have been working with the OCA project</td>
</tr>
<tr>
<td></td>
<td>Capacity building</td>
<td>Describe the capacity building that OCA is providing</td>
</tr>
<tr>
<td>Project performance</td>
<td>Relevance usefulness of project for staff and for service delivery</td>
<td>How useful was this process</td>
</tr>
<tr>
<td></td>
<td>Effectiveness in identifying challenges and prioritizing improvement plans</td>
<td>Do you think that the challenges identified during the assessment are the priority</td>
</tr>
<tr>
<td></td>
<td>Efficiency and participation of health facility staff, DHO and community in project implementation</td>
<td>How did you work with others on the project/How participatory was the process</td>
</tr>
<tr>
<td></td>
<td>Impact on quality improvement on staff, service delivery and health outcomes</td>
<td>Has the support from OCA improved the quality of services</td>
</tr>
<tr>
<td></td>
<td>Sustainability and scale up</td>
<td></td>
</tr>
<tr>
<td>Capacity building on staff</td>
<td>Needs assessment and effectiveness in identifying challenges</td>
<td>Where you involved in a capacity needs assessment</td>
</tr>
<tr>
<td></td>
<td>Impact of capacity building on staff and service delivery</td>
<td>Has the support from OCA improved the way you work</td>
</tr>
<tr>
<td>Strengths and weaknesses</td>
<td>Strengths in project implementation</td>
<td>What worked well during project implementation</td>
</tr>
<tr>
<td></td>
<td>Weaknesses in project implementation</td>
<td>Challenges did you face/ areas of improvement</td>
</tr>
<tr>
<td>Lessons Learnt</td>
<td>Lessons for scaling up and sustainability</td>
<td>Observations and triangulation</td>
</tr>
</tbody>
</table>

3.0 FINDINGS

3.1 PROJECT IMPLEMENTATION
The evaluation found that project implementation by OCA is well under way, and various project outputs have already been achieved. These include; conducting facility assessments, developing quality improvement plans, capacity building, and supporting implementation of quality improvement plans such as infrastructure improvement and support towards community engagement activities. All the respondents we interviewed were aware of the OCA project and approach, and the various activities that OCA was doing at the facilities. This is indicative that not only have the health facility assessments at the two facilities been completed, but they have also been presented to all the stakeholders. The evaluation
found that this was done in a collaborative and consultative manner, with all levels of the health system involved—community, facility, district, and national level. The evaluation further found that OCA staff have continued to provide the required support for project implementation at the facilities.

“I think we have been having several meetings with them, I think I have been taking part in those meetings, I think it has been going on well cause in each stage we are being involved in what is supposed to be done. we are able to get the feedback, there are people who come for some research and they gave us a feedback and we were able to participate in that feedback and was able to know what gaps they had faced and it really opened my eyes knowing where we are as in that area” DHO

According to health facility staff OCA conducted two to three assessments in each health facility. The assessments involved OCA volunteers walking through the health facilities to determine what infrastructural quality improvement would be needed, talking to health facility staff and asking them a series of questions to identify main challenges faced by the facilities both in terms of infrastructure and service delivery. Further, OCA volunteers accompanied health facility staff and community volunteers in outreach programmes where they were also able to interact with the community.

In both facilities, a limited number of staff were involved in conducting the assessments (mainly the in-charge and the nurses) and they feel that going forward such assessments should continue to involve health facility staff at different levels. They should also include key stakeholders in the community such as headmen and community volunteers because they know the major challenges that the community faces. According to health facility staff, they have never conducted any similar assessment at the health facility. Majority of health facility staff interviewed, mentioned that the assessments should be conducted regularly to ensure that gaps are identified, and action is taken quickly to continuously improve service delivery.

Similarly, CLTS champions highlighted that they’ve had a successful working relationship with OCA in implementation of the project so far. They indicated that they had regular meetings with OCA staff thus allowing the community to give feedback on activities being implemented. They further indicated that they have received capacity building which has improved reporting.

“This relationship has supplemented the efforts of the OCA staff in promptly and accurately receiving feedback from the community with regards to what gaps are there in WASH and the needs of the communities in implementing activities. The immersion model of OCA volunteers and staff and constant..."
interaction and training with/of CLTS champions has yielded the overall impact of increased building of toilets in communities.

3.2 PROJECT PERFORMANCE
3.2.1 RELEVANCE

The evaluation sought to assess how useful the OCA project is and whether it is needed at the facilities to improve the quality of service delivery. The evaluation found that all stakeholders found the assessments to be very relevant and comprehensive at identifying challenges and developing priority improvement plans. Staff at the facility indicated that they have not been involved in any similar comprehensive assessment before. Further, it was found that the project support that OCA is providing at the facility and in the community is needed in order to implement quality improvement plans and improve health outcomes.

Staff in both facilities found the assessments useful because, through the assessments they were able to identify priority areas that need improvement, and they are now hopeful that they will get the infrastructural development they need to serve the community better.

The CLTS champions expressed overly positive feedback with regards to the usefulness of the project in creating an enabling environment for their service provision. When asked on the presence and adequacy of the level of support from OCA, the CLTS champions highlighted the following;

“Yes. Its support has encouraged us to do our work in the community of encouraging people to maintain sanitation so that we could have a clean and safe environment.” CLTS 4

“The support from on call Africa has been good, it has encourage the interaction of us and other facility staff, because now the relationship is that, we are the bearers of information to the community, well we get the information from the health facility staff. Therefore, we have made the work of the health facility staff easier.” CLTS 2

OCA staff expressed that the project was very useful for the identifying and prioritizing of quality improvement challenges especially through the mixed methods approach of qualitative and quantitative assessment tools. The Likert scales applied for many variables of interest such as WASH categories being categorized as 0 for no running water to 3 for National standard water supply made identifying challenges at the health facility easy. However, one challenge that was observed was that sometimes National guidelines were not available/not very easily determined.

“This helps identify gaps because of the 0-3 scale, in spite of it being a long tool, it is comprehensive enough to identify and prioritize challenges... National guidelines weren’t available for some indicators” OCA staff member
OCA staff also supported the use of mixed methods when identifying and prioritizing challenges and improvement plans at the facility. While the quantitative tool was comprehensive and effective in identifying various challenges at the facilities, it was not adequate for prioritizing. The qualitative phase of the assessment was more useful at this stage of the process.

“I feel like the assessments work better when they are partnered with focus group discussions which gives people a lot of room to discuss and talk about things.” OCA

OCA volunteers also expressed that they found the assessments to be very relevant in having a comprehensive understanding of the challenges that facilities are facing and how they can be supported.

In addition to the information collected from the different stakeholders, it was observed that the activities that have been implemented so far have been in line with the theory of change, and the improvement plans developed at each of the facilities. As outlined in the TOC, project activities have been implemented through a consultative process, which has been documented extensively to allow for replication.

3.2.2 EFFECTIVENESS

The evaluation sought to assess how effective the OCA project was in identifying and prioritizing challenges at health facilities and developing priority quality improvement plans. The effectiveness of quality improvement plans to improve service delivery and health outcomes was not assessed as implementation will be done in the next phase of the pilot. However, the evaluation found that the OCA approach was very effective. Most of the stakeholders interviewed were able to mention at least two of the priority challenges identified by the assessments and agreed with the quality improvement plans that have been developed. Most of the CLTS’ indicated that OCA support was effective in enabling them to deliver health services in the community.

In both health facilities, the staff felt that the assessment was very helpful in identifying challenges and prioritizing improvement plans. In Chalimongela, they were able to identify the need for a mother’s shelter, a new borehole and the need for toilets in the community, while in Kanyanga the assessments helped them to identify the need for more Neighborhood Health Committee (NHC) members to be able to cover all the zones, the need for better power supply and the need for a mother’s shelter.

The assessments also led to identification of gaps in capacity of the health facility staff as well as the CLTS champions in the community which allowed for specific training to be provided such as conducting diagnosis on patients and administering of antibiotics. In terms of the infrastructure challenges that were identified through the assessments, plans have been made to improve them, there are plans to build mothers shelters in both facilities and a borehole has already been sunk in Chalimongela which has improved service delivery.

“The assessment was very much useful, for example we used to use man power water from the hand pump. Also, this boosted our morale to work.” In-charge
The assessment was very useful because some gaps were found, for example we never had champions but we do now.” In-charge

A key aspect of the assessments that contributed to the effectiveness of the approach was the consultative nature of the process and the presence of external/independent observers during the evaluation process. By immersing themselves in the facility activities, and consulting extensively with the various stakeholders, the volunteers were able to get a practical understanding of the challenges that were at the facility. In addition, the volunteers were also able to observe and validate what they were being told. This is a key component of the assessments that must be replicated at scale up.

It is evident that the CLTS’ champions have recognised and appreciated their role in the WASH value chain with regards to identifying and prioritizing improvement plans in their communities. Additionally, OCA’s support has improved the rapport and cooperation of local leaders and the community at large as is in the following comment;

“Yes, the support has improved the work because when there is a village gathering through the village administration or the clinic we are given chance to educate the community when sanitation matters therefore the support that comes from OCA has helped us implement our work.” CLTS

3.2.3 EFFICIENCY AND LEVEL OF PARTICIPATION

The evaluation sought to assess how efficient the project implementation process has been so far, and how participatory the process was. Efficiency was determined by assessing whether project activities were implemented as planned, with all stakeholders working together as planned. The evaluation did not review financial efficiency. The evaluation found that the project implementation was largely efficient, with some challenges on delay in implementation of some activities and communication being observed.

Generally, the health facility staff we engaged with felt that the assessments were well conducted. They mentioned that the walk through in the facility as well as the questions asked and meetings had were all useful and the right methods to use to assess the health facility. However, it was observed that there were some delays experienced in finalizing the assessments and developing quality improvement plans. As this was the pilot phase, and the period in which the health facility assessment tool was being developed, it was observed that there was an overlap in conducting the assessments and the start of implementation for some of the activities aimed at quality improvement. This overlap resulted in reduced efficiency in project implementation.

The OCA approach has been very collaborative and encouraging of stakeholder participation at all levels of the health system. In terms of participation of staff, the facility in-charge felt that there was need to engage all the different staff at the facility and other key community actors during the assessment. In both facilities, nurses and the in-charges were involved in conducting the assessments, but they felt that they should have also included the community health representatives, more EHT’s and CO’s at the facility when they were asked who else needed to be involved in the assessments. Overall, about a third of staff
interviewed felt that the project did well in terms of engaging them in activities. Table 3 summarizes the percentage of staff in each category who felt the level of engagement was sufficient.

Table 3: Staff perspective on level of engagements

<table>
<thead>
<tr>
<th>STAFF</th>
<th>N</th>
<th>FREQUENCY %</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLTS</td>
<td>10</td>
<td>40%</td>
</tr>
<tr>
<td>CO</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>EHT</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>INCHARGE</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>NURSE</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>16</td>
<td>62.5%</td>
</tr>
</tbody>
</table>

“My other staff members, community representative and the CHA”. In-Charge

“I think the EHT and the CO, even the headman.” In-Charge

Overall, the collaboration and communication among OCA, health facility staff, the DHO and community was reported to be consultative and participatory in the way that the OCA project was being implemented at the facilities and in the communities. It was observed that after some initial challenges, communication had improved at all levels of the collaboration. The challenges observed can be classified as health system challenges and OCA implementation challenges. Health system challenges included; the lack of clear-cut differences between roles of the NHC’s and CBV’s which played a role in overstepping and omission of certain activities during implementation; inaccurate reporting of activities happening at the health facility and outreach programmes and delays in giving feedback whereas OCA implementation challenges included; short notice on implementation of activities and leaving out some people during implementation of some activities. It was observed that there was need to continue working on improving communication at all levels including ensuring open and clear communication of planned activities, roles, and responsibilities in implementing the activities, progress on implementation of activities and feedback. These challenges can also be mitigated through relationship building with the DHO.

The evaluation found that the OCA project has enhanced communication between the health facility staff and the community volunteers. It was observed that there was need for more support to enhance communication between the health facility and the DHO. The planned quarterly meetings with all project stakeholders present a great opportunity for communicating all planned activities and expected participation from all stakeholders well in advance. It also presents an opportunity to align expectations among OCA, the facility staff and the DHO on what can be achieved given available resources from both the government and the project.
3.2. IMPACT ON QUALITY IMPROVEMENT

The evaluation sought to assess the impact of quality improvement by assessing how staff capacity building was impacting service delivery at the facility and in the community so far. The evaluation found that the project was already having a positive impact and was expected to lead to improved quality service delivery and health outcomes upon completing the implementation of planned improvement plans.

Overall health facility staff feel that the OCA project has had some impact on service delivery and health outcomes and could have a greater impact once the project is complete. So far, health facility staff have mentioned that through mentorship they received, they are able to better diagnose patients and administer antibiotics. They also mentioned that communities have better sanitation because of the toilets that have been built through the OCA project and as a result, they have noticed less diarrhoea cases. They believe that once the other infrastructure developments are completed such as the building of mother’s shelters, service delivery will further improve.

“The quality improvement plan will improve service delivery because, for example, if we have electricity, water and network it will boost our ability to work. Even when a mother shelter is put it will attract women to come and deliver here.” In-charge, Chalimongela

The observations by the facility staff is supported by the CLTS Champions who reported that the activities they are implementing in the community as a result of OCA support is already showing improved health outcomes. They have observed behavioral change with regards to WASH practices through the interactions and trainings they offer to the communities.

“It changes and improvements that have happened regarding health is that we do not have many health challenges like diarrhoea that we had in the past.” CLTS 4

“Now people have toilets which they did not have after implementing this program people have now started building toilets which they did not have in the past so this is the development and the changes that can be seen.” CLTS 3

“These changes will continue because now people know the importance of sanitation people are now washing their hands using trade it’s because of the lessons that they have learned therefore even when on core Africa comes after many years they will find these changes.” CLTS 1

The support rendered goes beyond the ability to reach out to communities, but includes materials and operational support which they rarely receive from government aids.
In addition to the support received from OCA, the facility staff have equally contributed to the ease of work of the CLTS champions over the project duration.

“We are supported with materials like masks stationary and materials to use in the community, The facility staff help us with training if there is any need and also as a means by which we receive our wages for the work we do.” CLTS 1

“The support from OCA is very small which is K50 a month and it is very little but all in all we work well with the staff members from the facility.” CLTS 03

“Yes we do receive support we normally go with them sometimes in the community to prove to the community that we have been sent by the facility to come and do these meetings.” CLTS 3

The full impact of the project will be assessed and determined at the end of project implementation.

3.2.5 SUSTAINABILITY AND SCALE-UP

The project sought to assesses sustainability by assessing whether the project had put in place mechanisms/strategies that would ensure that the project activities leading to quality service delivery and improved health outcomes for the community would continue at the health facility when implementation of the OCA project ended. The evaluation found that the approach that OCA was using would lead to sustainability of project activities if the project implementation continued as planned. It was observed that by taking a health systems approach and being consultative, OCA was addressing the priority challenges that health and community workers, needed to be addressed. The capacity building through formal and informal training and mentorship was observed to already be changing the behaviour of health facility staff, and the impacts of the planned infrastructure development was also expected to go beyond project duration period.

Generally, health facility staff feel that as long as the quality improvement plans can be completed with support from OCA, especially on infrastructure development, then project outcomes can be sustained and ultimately service delivery improved. They feel that so far, they have already improved how they are providing services to the community because of the OCA project and that will not change even after the project comes to an end. Majority of the staff interviewed are happy with the quality improvement plans (Table 4). However, some health facility staff felt that the quality improvement plans were missing some details on how implementation would be done and therefore they felt they could be improved further.

<table>
<thead>
<tr>
<th>Table 4: Staff perspectives on quality improvement plan</th>
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<tbody>
<tr>
<td><strong>STAFF</strong></td>
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<td>CO</td>
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<tr>
<td>EHT</td>
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The CLTS champions were also mostly optimistic of the potential for sustainability of the project even in the absence of OCA. They reported that the continuous and repetitive training will be a key driver for sustainability and the instalment of facilities and equipment/infrastructure in the community will ensure continued good WASH practices in the community in the long run.

“Because as long as we live we will be able to teach them and encourage them to continue.” CLTS 07

“It will proceed the changes will proceed if the water challenge has been sorted out, because most of the time we suffer the challenge of water. There is no water in this area the only place to draw water is far away so we usually come to the dam to draw water. And mostly animals like cattle and pigs come to the same place for water. So that is a challenge but if there could be more hand pumps, sanitation would continue because we will be here to maintain that.” CLTS 4

With regards to sustainability, the OCA staff and volunteers reported there is need to ensure that the activities that OCA will be implementing are taken up by the government in the long run. One way to ensure this is to have realistic standards of the activities and interventions so that the government can easily adopt them within the current systems, capacity and limitations. To address this, the community should be central in the implementation processes and equipped to own and drive the projects; in which OCA must be imbedded in communities further as partners and not experts. For example; the rural health post staff should be aware that OCA and other similar organizations are partners and not experts in service delivery improvement.

“If we have an extensive training so that even as facilities work they understand what is at stake and how that project is supposed to run, that would be more effective. The most difficult part is having the right people doing these things especially from the government side” OCA

The overall consensus was that the government cannot solely ensure sustainability of the projects over time as they do not have the capacity, rural networks and systems to support them. OCA and other
projects like it should consider sustainability issues and consider how they can support the DHO, health facilities and communities to sustain them, however ultimately sustainability lies with MOH.

“So sometimes the project may start well but by that time it is coming to reach the community it can’t work because maybe there is no one to monitor or maybe there is low funding the money that was supposed to be funded has been cut off and sent somewhere else the projects end up failing. Now that I think of it sometimes this project may be done better by NGOs.” **OCA staff member**

Other identified areas for sustainability support were the provision of financing for other facilities necessary for the effectiveness of suggested systems of improvement such as electrification of health facilities, improved road access networks among others. Monitoring and evaluation of projects was also reported as necessary for the sustainability of the project with the following comment;

“Then in terms of M&E it is important to have someone staying in the community to monitor what is taking place. Because what we do is we spend one week in the community and another week back at the office so there are a lot of gaps within that week when you are not in the community to monitor. So there is need to have stuff that are dedicated to monitoring the project and seeing that things are done when and how they should be done.” **OCA staff member**

### 3.3 CAPACITY BUILDING ON STAFF
#### 3.3.1 NEEDS ASSESSMENT

The evaluation set out to determine how relevant and effective the needs assessment was in determining capacity gaps of health facility staff and community workers. We found that the needs assessment was relevant in determining capacity gaps of both health facility staff and community workers. The health facility staff found the assessment useful because their main capacity gaps were identified and they later received training and mentorship from OCA to fill the identified capacity gaps.

However, the evaluation found that while the needs assessment was relevant in identifying capacity gaps there is need to make it more effective and efficient. The needs assessment to determine capacity gaps was conducted as part of the other assessments at the health facility. Some of the assessments had a few questions about capacity gaps of health facility staff and community workers but these questions were not exhaustive. As a result, there other capacity gaps that could have been missed. Health facility staff feel that it would be useful to have a separate capacity needs assessment which is more focused on capacity needs. The capacity needs assessment should be conducted quarterly and should involve more staff at the health facility and the community workers
“It wasn’t an independent assessment like just for capacity building. I think they were just few questions in the assessments they had been doing that were connected to assessing the needs for capacity building for staff. So, for that one I feel it needs to be improved. Maybe if they can just have a separate assessment just to or a tool used for each and every staff like that to assess the needs for capacity building not incorporating capacity building questions on a different kind of assessment.” EHT-Kanyanga

TRAINING AND MENTORSHIP

With regards to training and mentorship the evaluation found that both were relevant and effective in filling capacity gaps of both health facility staff and community workers that were identified by the needs assessment. According to health facility staff they underwent both formal and informal trainings. The formal trainings were conducted in form of workshops whereas the informal trainings were conducted as they worked. Some health facility staff also received mentorship where they would work alongside OCA doctors and volunteers and learn from them. The evaluation found that the mix of training and mentorship worked well, however, both activities could be formalized to ensure that they are being conducted when capacity gaps are identified and to classify which topics should be taught through training and which ones should be focused on during mentorship.

“like I said earlier, when I am at work, we would have some discussions as in we would just sit and discuss maybe antenatal. I guess when we do ANC booking there’s a time when we normally identify a gestational age less than 14 weeks so we were discussing as how can we help these mothers to start ANC early so that we are able to identify gestation age before 14 weeks. So, we had to sit we discussed.................
Also, some diseases like hepatitis, I remember last time we had to sit and discuss with the same doctor. So most of the time, I do sit with them to discuss some diseases and challenges like identifying of pregnancies early before 14 weeks.” Nurse, Chalimongela

According to health facility staff the training and mentorship was also extended to CBVs who they work with in the community. This was very useful because they were able to identify capacity gaps of CBVs in the community and train them to improve service delivery at the community level.

While the training and mentorship were found to be useful in filling capacity gaps and therefore a step to improving service delivery, health facility staff felt that more people at the health facility need to be trained. This means there would be need to keep a record on who has been trained and mentored and on which topics to ensure that eventually most of the staff are trained on topics applicable to them.

Some facility staff mentioned that they had undergone training with other organizations and also had workshops in the past. When asked to compare the trainings with those provided by OCA, they felt that all training programs were useful in enabling them to improve service delivery to the community.
3.3.2 Impact of capacity building on staff and service delivery

The evaluation sought out to determine whether the training and mentorship improved capacity of health facility staff and community workers and whether this led to an improvement in service delivery. Generally, the evaluation found that the training and mentorship had positive impact on capacity of health facility staff and community workers and ultimately has led to improvement of service delivery. The table below summarizes the percentage of each type of health facility staff that was interviewed that felt that their capacity increased as a result of OCA activities. Majority of staff interviewed (87.5%) felt that their capacity had increased because of OCA activities.

Table 5: Health Facility Staff and CLTS - Self reporting increased capacity

<table>
<thead>
<tr>
<th>STAFF</th>
<th>N</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLTS</td>
<td>10</td>
<td>90%</td>
</tr>
<tr>
<td>CO</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>EHT</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>INCHARGE</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>NURSE</td>
<td>2</td>
<td>50%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>16</td>
<td>87.5%</td>
</tr>
</tbody>
</table>

Through the training and mentorship health facility staff and community worker capacity were built on how to administer anti-biotics, how to diagnose patients, improving sanitation in the community and also ANC delivery. The staff mentioned that the training had a positive impact on their service delivery because they improved on how they were conducting their work.

“For instance, on antibiotics, we used to give to anyone who came complaining about a flu but now we know how to give patients.” In-charge-Kanyanga

“I think, let me just say especially when the training of community total led champions has brought an improvement because from the time the champions were trained, at least it has helped us identify, we can say the extent of the problem that we had in terms of sanitation in the community because based on the baseline data that the champions collected in the initial stage of the program implementation, community led total sanitation. Yeah and we are seeing it to be a total success because according to the reports that they have been bringing, people have now started appreciating the need to have a toilet and because of that I think from the reports, the surveillance data that they collect on a weekly basis, I’ve seen a reduction in the number of cases of diarrhoea. So, me as an EHT also I have seen an improvement in terms of providing good sanitation to the community and also preventing diarrheal, people with diarrheal diseases. Because toilets are being built...
because of the sanitation program that has started. So, I have seen an improvement.”

EHT-Kanyanga

Staff also mentioned that because of the training they now know how to handle certain cases such as GBV.

“We are supposed to have a register at this facility for recording every case and we need to have volunteers who teach about it.” Nurse-Kanyanga

The CLTS champions exceedingly appreciated the trainings offered by OCA and the ability offered to strategically and clearly communicate the needs realized in the assessments. The impact has already been realized by the CLTS champions which has increased overall morale to continue the work as many community members are responsive to the trainings and activities they provide in the community.

“The training was quite good and it helped us a lot because at first we only had three CLTS so when on call Africa came this selected us from three zones to become champions because previously it was challenging that’s why in some areas we had no toilets. So after this program in found that nearly in any area there are toilets” CLTS 3

The training also created proper recognition of the CLTS champions by the community members in that the content they presented is accepted and validated;

“This training has helped in the community in that firstly people have already started building toilets, secondly people now know what we do in the community and they can't easily mistake us, whenever you arrive address it in place people know the reason why you are there.” CLTS 2

“There is a difference in That I am now able to go around and remind people because I am a champion. On the benefits of sanitation and water in the community” CLTS 1

In addition to providing solutions to already existing and identified problems, the CLTS champions agree that some content of the trainings was new to them, hence new to the communities alike and was cause for action among them;

“Open defecation was something that was surprising though we were used before this CLTS programme came over. Three quarters of those without toilets liked the
The OCA staff positively remarked on the relevance of the training to staff in health facilities and the role of the project in improving service delivery in that there was notable informal transfer of skills from the experts to the facility staff and community volunteers during engagement.

“In but these are things that we’re done informally as you work together you share ideas because sometimes when you call it a training it’s like you are teaching people to say this is how this should be done and there could be some resistance there but what we were doing was like learning from each other.” OCA

In their outlook, the model of immersive community engagement has been effective and is evidenced through the notable better antibiotic stewardship practices of health facility staff and the 135 new toilets built by the local communities. They expressed that the facility staff, for example, are often already aware of their gaps and needs before the assessment identifies them, and hence most capacity building needed is with regards to designing systems which address the gaps identified.

3.4 STRENGTHS AND WEAKNESSES OF PROJECT IMPLEMENTATION

3.4.1 STRENGTHS (what has worked well so far)

Generally, the OCA project implementation has worked well so far as highlighted the positive project performance above. The new approach of systems strengthening, and working with the different levels of the health system to achieve improved quality service delivery has been collaborative and consultive and has resulted in quality improvement plans that will lead to a sustainable outcome if project activities are implemented according to plan. The assessments at health facilities were effective in identifying challenges faced by the health facilities.

OCA staff also expressed this, reporting that restructuring of the intervention approach was successful and necessary for the target communities as compared to the previous approach. The current approach is more holistic and addresses all the six WHO pillar of an effective health system strengthening approach.

“Bringing the community to the table worked well and also being part of the community. Because when you go and stay in the community that helps.” OCA

The approach being both quantitative and qualitative were appreciated by the OCA staff considering that the mixed methods complemented each other with collecting accurate and in-depth information about the needs for service quality improvement. With regards to the assessment tool, OCA volunteers highlighted that overall; though complex in itself, was easy to develop;
3.4.2 WEAKNESSES (AREAS OF IMPROVEMENT)

An observed weakness is there is a lack of ownership of the quality improvement plans and assessments. Health facility staff refer to them as part of the OCA project, but these should be included as part of their daily work, they should feel that they can use these tools to continuously improve quality in their facilities. This is expected as the project is in early days of implementation.

Another limitation that was reported in the implementation of the project is the lack of adequate funding for ‘more intensive community engagement’ activities such as conducting focus group discussions with more community members of various socio-demographics as compared to the targeted few initially involved in the assessments. OCA volunteers equally highlighted that the duration of volunteer placement was short and consequently insufficient for continuation of volunteer efforts owing to gaps in placement schedules. Further challenges arising from gaps in placement include mismatch in techniques and methods applied by prior and subsequent volunteers on the same intervention.

Other than challenges with open communication among project, facility and DHO staff, internally; OCA’s project model which allows for close interaction between volunteers and community members remains limited due to cultural and lingual barriers. Inaccurate translations in assessments and feedback during interactions have created room for bias in responses received due to the fragile translation channels as; OCA volunteers expressed that questionnaires administered exclusively by facility staff were also prone to bias and recommended that more local OCA volunteers be recruited and included in assessments to mitigate discrepancies in patient feedback and reduce bias.

“I don’t speak the local languages and because some of the questions were, I don’t know they use complicated English lines which I guess were quite hard to get across. So it can be difficult to get across if we didn’t have someone who spoke Tonga there with us and I think it would be for OCA to consider someone who speaks Tonga to be doing that survey, especially the CBVs or NHC members… yeah I think another consideration just to make sure that there is someone out there who can get the message across in a clear way for the people trying to hear you” OCA

3.5 LESSONS LEARNT FOR SCALE-UP AND SUSTAINABILITY

The following are some of the key lessons learnt from project implementation so far that are important for sustainability and Scale-Up

- In order for the quality improvement plans to be implemented and work, OCA should continue involving staff at the facility as well as the community so that they can continuously identify challenges and brainstorm solutions together. The approach is effective in ensuring local ownership of project activities and leads to systemic change and development.
• Generally, the assessments worked well and was effective in identifying the challenges and priority improvement plans at the health facility. The development of a standardized HFA Tool is very important in collecting data and information that can be used by different stakeholders for quality improvement purposes. Consideration should be made to have a separate assessment for capacity needs to ensure that capacity gaps are captured comprehensively.

• As OCA assists MOH to scale-up this project into new districts and health facilities, there should be consideration of whether the health facilities have had any assessments. This will avoid collecting data on existing information and avoid respondent fatigue and familiarity. As part of the scale-up plan OCA can include steps in the assessment to determine whether there is any existing data on their points of interests and then establish how to leverage this existing data so that volunteers and staff are not constantly collecting additional data.

• The mixed approach that includes both training and mentorship in a formal and informal way works well for project implementation. This takes away the feeling of project imposition on the trainees while allowing for volunteers to experience full-time, the experiences of the target trainees which has rendered the project successful in approach.

• Both formal and informal training mechanisms are important for capacity building of staff at the health facility. There is need for an informal training and mentoring form to be used to capture informal training taking place, and for it to be replicated with other facilities and other staff. The current facilities are highly similar in operational characteristics that the approach is relatively successful, yet, when scaling-up, there is need for continuous refining and adaptation of the training methods and assessment tools to cater for arising differences in other catchment areas.

• As the project continues and scales up to other districts and health facilities, OCA should continue interacting and cooperating with other organizations operating in similar catchment areas and projects to ensure holistic and standardized approaches in designing unique methods for replication and adaptation of the assessments. Sharing publications of approaches used in studies and implementation with other stakeholders will reduce duplication of effort and make scale up more cost effective both in material and human resource.

• There is need to continued fostering of ownership among health facility staff of the assessments as well as the quality improvement plans. Some staff are currently view activities as “OCA project activities”. Use of visual aids /posters can help to ensure that facility staff are always thinking about how to implement the quality improvement plans in their daily work. Moreover, from inception, there must be clear emphasis that OCA should not be considered an external expert but a partner in the project so that ownership is established from the beginning at the community, facility level and the community.

• In the presence of the various non-governmental entities; the Government remains a key stakeholder in the sustainability and scaleup of the project as the relationship between OCA and the two current facilities was built over a long period of time, yet; any new facilities on the project will need extra support from the government in a form of mandate to be subject to the assessments and partner in the implementation.
To maximise training efforts during scale-up, the project should utilise government staff to play the volunteers’ roles as mentors, using the same informal and formal training models employed. This of course should be implemented with consideration to the current healthcare system capacity, including staffing and administration.

4.0 CONCLUSION

This process evaluation was conducted to assess the performance of the pilot activities implemented by OCA on improving quality service delivery and health outcomes at two rural health posts in Zimba district. The evaluation also aimed to assess the impacts of project implementation so far to determine the relevance, effectiveness, efficiency, impact, sustainability, and level of community participation of project activities. Further, the evaluation aimed to highlight the key strengths and weaknesses in implementation so far, and lessons learnt for scale-up and sustainability. The evaluation found project implementation so far to be relevant and effective, with a sustainable approach. The project is already having positive impacts on staff capacity, improved outcomes and improved service delivery. It is expected that completion and scale up of the project will lead to sustained quality improvements in service delivery of rural health facilities.
ANNEXES

ANNEX 1: A. Key Informant Interview Guide: Ministry of Health, Provincial Health Office and District Health Office
(Various staff members)

Informed Consent: “We are from PRS, and we are working with On Call Africa and Ministry of Health on the Rural Health Service Package project being implemented in Zimba District. We are interested in learning about your experience working on this project and working with the project team to implement activities aimed at prioritizing health challenges, developing quality improvement plans and implementing activities aimed at improving health service delivery at the rural health facility. Your perspective is very important in helping to learn what has worked well on the project and areas of improvement to scale-up and implement the project in other Rural Health Facilities across the country.

Would you mind answering some questions? This interview should take less than 1 hour. Your participation is entirely voluntary, and you can stop the interview at any time. I will record the interview so that I can capture all the things we discuss. The information I am collecting is for research purposes only and will not be traced back to you in any way. All insights gained will be reported in general terms. May I continue?”

Date: ___________________________
Location: ______________________________________
First name of informant: ______________________________________
Phone Number: ________________________________
Occupation: ________________________________
Years in position: _________________
Years at location: _________________

Work Background

1. Can you tell me about your role and the specific work you do in relation to service delivery at Rural Health Facilities?
2. What are some of the key challenges that rural health facilities face to deliver quality health services to the communities they serve? (Probe per health systems pillar)
   a. Service delivery
   b. Workforce
   c. Health Information
   d. Essential Medicines
   e. Financing
   f. Leadership and Governance
3. Describe to me the process of how these challenges have been established in the past/in other facilities where OCA is not working? (Probe: ask whether any assessments were done)

**Interaction with the OCA project and staff**

4. Describe to me the process of how you have been working with the OCA project to develop a model Rural Health Service Package at the two rural health facilities in Zimba District?
5. How participatory did you find this process? (Explain in terms of communication with project staff, input into project implementation and providing feedback)
6. How useful was the process for identifying and prioritizing quality improvement challenges at the two facilities in Zimba?
7. What have been the key outputs/deliverables of this project so far? (here you expect them to mention the HCF assessment tool, assessment reports, quality improvement plans and training of staff)
8. Explain how useful these deliverables are for improving the quality of health service delivery at Rural Health Facilities? Probe for how useful each of these deliverables has been:
   a. HCF assessment tool and assessment reports
   b. Quality improvement plans and
   c. Training of staff
9. Describe any other approaches/projects that the ministry has been implementing aimed at improving health services delivery using a health systems approach in rural health facilities
   a. What are the key similarities and differences with the OCA project?
   b. Which approach is preferable in achieving improved health service delivery and why?
10. Explain how project implementation so far has contributed to strengthening community health system structures at the two facilities?
11. What have been the key strengths and key areas of improvement in the way that the OCA project has been implemented at the two facilities?
12. What are the key lessons that the ministry (CHU /DHO) has learnt through working with the OCA project?

**Impact on Staff Capacity**

13. Describe the capacity building that OCA is providing to staff at the health facilities?
14. How relevant is this training to the staff at the health facilities in helping them improve the quality of service delivery? (Explain)

**Sustainability and Scale Up**

15. What are the key outcomes/impacts on quality service delivery and community health outcomes that you have observed from the OCA project so far?
16. How can the OCA project be scaled up to other Rural Health Posts? (Explain)
17. What additional support is required to improve the health systems strengthening support that OCA is giving to the ministry and to the facilities?

18. Is there anything else you’d like to tell us about ways of improving quality health care service delivery in rural health facilities

Thank you very much for your time.
Annex 2: B. Key Informant Interview Guide: Health Facility Staff (In-Charge, Nurse, EHT and CHA)

Informed Consent: “We are from PRS, and we are working with On Call Africa and Ministry Of Health on the Rural Health Service Package project being implemented in Zimba District. We are interested in learning about your experience working on this project and working with the project team to implement activities aimed at prioritizing health challenges, developing quality improvement plans and implementing activities aimed at improving health service delivery at the rural health facility. Your perspective is very important in helping to learn what has worked well on the project and areas of improvement to scale-up and implement the project in other Rural Health Facilities across the country. Would you mind answering some questions? This interview should take less than 1 hour. Your participation is entirely voluntary, and you can stop the interview at any time. I will record the interview so that I can capture all the things we discuss. The information I am collecting is for research purposes only and will not be traced back to you in any way. All insights gained will be reported in general terms. May I continue?”

Date: ___________________________

Location: ______________________________________

First name of informant: ________________________________

Phone Number: ________________________________

Occupation: ________________________________

Years in position: _________________

Years at location: _________________

Work Background

1. Can you tell me about your role and the specific work you do in relation with this rural health facility?
2. What are some of the key challenges that the rural health facility faces to deliver quality health services to the community?

Interaction with the OCA project and staff

1. Describe to me the process of how you have been working with the OCA project at this facility and what support they have been providing
   a. To the facility and
   b. To You specifically?
2. Where you involved in any of the assessments conducted by OCA aimed at identifying key challenges and developing quality improvement plans at the HFC? Explain how you were involved and what information you provided.
3. How many assessments were done and please describe this process to us as well as you can remember it?
4. How useful was this process for how you conduct your work at the health facility?
5. How useful was the process for improving the way you deliver services to the community?
6. Have you ever been involved in any similar assessment process at this facility? If yes,
   a. Describe the process
   b. How does it compare to the process you were involved in with OCA?
   c. And which one do you prefer and why?
7. How often/when should such assessments be done?
8. How would you want the assessment to be done in future and how would you like to be involved?
9. Which other health facility staff should be involved when these assessments are being conducted?
10. Do you think that the challenges identified during the assessment are the priority challenges at this health facility? Why?
11. Do you think the quality improvement plans developed will lead to improvement in the quality of health services the facility gives to the community? How?
12. Do you have any other suggestions on how challenges can be identified and addressed that OCA should consider in the future?

**Impact on Staff Capacity**

1. Where you involved in a capacity needs assessment to review your capacity requirements from OCA? If yes
   a. Describe the needs assessment to me
   b. Did the assessment adequately identify your training/capacity needs?
2. Did you receive any training/capacity building from OCA? If yes
   a. Describe the training to us, what did you learn?
   b. Did the training change the way you conduct work? How?
   c. What other training do you need from OCA?
3. Did you receive any mentorship through OCA? if yes,
   a. Describe the mentorship
   b. Which was more useful between the training and the mentorship and why?
4. Have you ever received similar training and mentorship from any other organization? If yes
   a. How did it compare with the training you received from OCA? Which one do you prefer and why?
5. Has the support from OCA improved the way you work with CBVs and/or CLTS champions that work with the facility? How?
6. Has the support from OCA improved the quality of services that CBVs and/or CLTS Champions deliver to the community? How?
7. Is there anything else you’d like to tell us about ways of improving quality health care service delivery rural health facilities

**Sustainability and Scale up**

1. What have been the key changes to improve the quality of service delivery to the community that you have made so far as a result of the OCA project?
2. Will these changes continue even after OCA support comes to an end? Why?
3. What additional support do you require to improve the quality of service delivery at the facility?
Thank you very much for your time.
ANNEX 3: C. Key Informant Interview Guide: CLTS Champions

Informed Consent: “We are from PRS, and we are working with On Call Africa and Ministry of Health on the Rural Health Service Package project being implemented in Zimba District. We are interested in learning about your experience working on this project and working with the project team to implement activities aimed at prioritizing health challenges, developing quality improvement plans and implementing activities aimed at improving health service delivery at the rural health facility. Your perspective is very important in helping to learn what has worked well on the project and areas of improvement to scale-up and implement the project in other Rural Health Facilities across the country. Would you mind answering some questions? This interview should take less than 1 hour. Your participation is entirely voluntary, and you can stop the interview at any time. I will record the interview so that I can capture all the things we discuss. The information I am collecting is for research purposes only and will not be traced back to you in any way. All insights gained will be reported in general terms. May I continue?"

Date: ___________________________
Location: ______________________________________
First name of informant: ________________________________
Phone Number: _____________________________________
Occupation: ________________________________
Years in position: _________________
Years at location: _________________

Work Background
1. Can you tell me about your role and the specific work you do in relation with your community?
2. What are some of the key health challenges that the community faces?
3. What are some of the key challenges that the community faces in terms of Water, Sanitation and Hygiene, and issues around Open Defecation? (Clean environment, Hand washing, Open defecation, Dish rack and Pit Latrine)

Interaction with the OCA project and staff
1. Describe to me how you have been working with the OCA project?
2. What activities you have been implementing and what support has OCA has been providing to you specifically to enable you to implement these activities? (wash activities around clean water, clean environment, hand washing, open defecation, pit latrines, dish racks)
3. Has this support that you have receiving been adequate? Why?
4. Were you implementing any of these activities before the OCA?
5. Do you face any challenges in implementing the OCA project activities in the community? Why?
6. What additional support do you need to further improve Water, Sanitation and Hygiene (WASH) practices in your community?
**Impact on Staff Capacity**

8. Did you receive any training from OCA? If yes
   a. Describe the training to us, what did you learn?
   b. Did the training equip you to promote CLTS activities to your community? (explain)
      How and why?
   c. What activities do you conduct in the community after the training that you were not doing before the training, and how often? (wash activities, monitoring tools)
   d. Explain how the training you received has changed how you implement activities in the community?

9. Do you receive support from health facility staff to implement your activities in the community?
   Describe this support.

10. Has the support from OCA improved the way you work with health facility staff? How?

11. Has the support you have received from OCA improved the way you implement your activities in the community? How? (Remind them of any other support mentioned earlier apart from training)

12. Have your activities in the community improved Water, Sanitation and Hygiene (WASH) practices in this community? Explain

13. Is there anything else you’d like to tell us about ways of improving Water, Sanitation and Hygiene (WASH) in the community that OCA can support?

14. What additional support do you need to implement your activities?

**Sustainability and Scale up**

4. What have been the key changes to improve health outcomes in your community that you and the community have made so far as a result of the OCA project and support?

5. Will these changes continue even after OCA support comes to an end? Why?

6. What additional support do you require to improve health outcomes in the community?

Thank you very much for your time.
ANNEX 4: D. Key Informant Interview Guide: OCA STAFF

Informed Consent: “We are from PRS, and we are working with On Call Africa and Ministry of Health on the Rural Health Service Package project being implemented in Zimba District. We are interested in learning about your experience working on this project and working with the project team to implement activities aimed at prioritizing health challenges, developing quality improvement plans and implementing activities aimed at improving health service delivery at the rural health facility. Your perspective is very important in helping to learn what has worked well on the project and areas of improvement to scale-up and implement the project in other Rural Health Facilities across the country. Would you mind answering some questions? This interview should take less than 1 hour. Your participation is entirely voluntary, and you can stop the interview at any time. I will record the interview so that I can capture all the things we discuss. The information I am collecting is for research purposes only and will not be traced back to you in any way. All insights gained will be reported in general terms. May I continue?”

Date: ___________________________
Location: ______________________________________
First name of informant: ________________________________
Phone Number: ________________________________
Occupation: ________________________________
Years in position: _________________
Years at location: _________________

Work Background

1. Can you tell me about your role and the specific work you do in relation with this project aimed at developing a model Rural Health Service Package and improving the quality of health service delivery at the rural health facility?
2. What are some of the key challenges that you have identified that rural health facilities face to deliver quality health services to the community?

Interaction with Ministry of Health and Health Facility Staff

1. Describe to me the process of how you have been working with MOH staff, Health Facility Staff and CBVs at the two rural health facilities in Zimba District?
2. How participatory is this process? (Explain)
3. How useful was the assessment and process for identifying and prioritizing quality improvement challenges at the two facilities in Zimba? Explain
4. What worked well in the approach you used, and what did not work well? How can it be improved in future?
5. What activities did you set out to implement at the start of the pilot that were not implemented and why? What lessons can be used for future planning?
6. How did you collaborate with CHU, DHO, HCF Staff and CBV’s? what worked well, what did not work well.
7. What were the key challenges that you faced at project implementation and key lessons learnt with regards best practice for rural health systems strengthening going forward?

**Impact on Staff Capacity**
8. Describe the capacity building that OCA is providing to staff in the facilities?
9. How relevant is this training to the staff at the health facilities in helping them improve the quality of service delivery? (Explain)
10. What changes have you observed among staff who have undergone training/capacity building?

**Sustainability and Scale Up**
11. How can the OCA project be scaled up to other Rural Health Posts? Explain
12. What additional support is required to improve the health systems strengthening support that OCA is giving to the ministry and to the facilities?
13. Is there anything else you’d like to tell us about your experience of improving quality health care service delivery in rural health facilities.

Thank you very much for your time.
ANNEX 5: D. Key Informant Interview Guide: OCA Volunteers

Informed Consent: “We are from PRS, and we are working with On Call Africa and Ministry of Health on the Rural Health Service Package project being implemented in Zimba District. We are interested in learning about your experience working on this project and working with the project team to implement activities aimed at prioritizing health challenges, developing quality improvement plans and implementing activities aimed at improving health service delivery at the rural health facility. Your perspective is very important in helping to learn what has worked well on the project and areas of improvement to scale-up and implement the project in other Rural Health Facilities across the country. Would you mind answering some questions? This interview should take less than 1 hour. Your participation is entirely voluntary, and you can stop the interview at any time. I will record the interview so that I can capture all the things we discuss. The information I am collecting is for research purposes only and will not be traced back to you in any way. All insights gained will be reported in general terms. May I continue?”

Date: __________________________
Location: ______________________________________
First name of informant: ________________________________
Phone Number: ______________________________________
Occupation: ______________________________________
Years in position: _________________
Years at location: _________________

Work Background

3. Can you tell me about your role and the specific work you do in relation with this project aimed at developing a model Rural Health Service Package and improving the quality of health service delivery at the rural health facility?
4. What are some of the key challenges that you have identified that rural health facilities face to deliver quality health services to the community?

Interaction with Ministry of Health and Health Facility Staff

14. Describe to me the process of how you have been working with MOH staff, Health Facility Staff and CBVs at the two rural health facilities in Zimba District?
15. How participatory is this process? (Explain)
16. Describe to me the assessments you conducted at the rural health facility in Zimba. How useful was this assessment and process in identifying and prioritizing quality improvement challenges at the two facilities in Zimba? Explain
17. What worked well in the approach you used, and what did not work well? How can it be improved in future?
18. How often should assessments like these be done at the health facility, and who should conduct them? Do rural health facilities have the capacity to conduct such assessments on their own?
19. What activities did you set out to implement at the start of the pilot/assessment that were not implemented and why? What lessons can be used for future planning?
20. How did you collaborate with MOH HQ, DHO, HCF Staff and CBV’s? what worked well, what did not work well.
21. What were the key challenges that you faced at project implementation and key lessons learnt with regards best practice for rural health systems strengthening going forward?

**Impact on Staff Capacity**
22. Describe the capacity building that you provided to staff in the facilities and which staff received it particularly?
23. How relevant is this training to the staff at the health facilities in helping them improve the quality of service delivery? (Explain)
24. What other capacity building support do staff at the health facilities need to improve quality service provision?

**Sustainability and Scale Up**
25. How can OCA ensure sustainability of their project activities at the rural health facilities? (Explain)
26. How can the OCA project be scaled up to other Rural Health Posts? Explain
27. What additional support is required to improve the health systems strengthening support that OCA is giving to the ministry and to the facilities?
28. Is there anything else you’d like to tell us about your experience of improving quality health care service delivery in rural health facilities.

Thank you very much for your time.