Zambia's 1000 Most Critical Days Programme: Results From the 2016 Process Evaluation (First Component)

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American Institutes for Research and Palm Associates

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Abbreviations and Acronyms

C-IYCF	Community-Infant and Young Child Feeding
CHV	Community Health Volunteer
CHW	Community Health Worker
CLTS	Community Led Total Sanitation
DACO	District Agriculture Coordination Office
DfID	Department for International Development
DNCC	District Nutrition Coordinating Committee
EHT	Environmental Health Technician
FGD	Focus Group Discussion
GMP	Growth Monitoring Promoter
IEC	Information Education and Communication
IFA	Iron and Folic Acid
IMAM	Integrated Management of Acute Malnutrition
IYCF	Infant and Young Child Feeding
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MCDMCH	Ministry of Community Development, Mother and Child Health
MCDP	Most Critical Days Programme
MIS	Management Information Systems
MLG	Ministry of Local Government
MOA	Ministry of Agriculture
MOE	Ministry of Education
MOH	Ministry of Health

MSVTEE	Ministry of Education, Science, Vocational Training, and Early Education
MUAC	Mid-Upper Arm Circumference
NFNC	National Food and Nutrition Council
NGO	Non-Governmental Organisation
ODF	Open Defecation Free
SHN	School Health and Nutrition
SLTS	School-Led Total Sanitation
SMAG	Safe Motherhood Action Group
SUN	Scaling Up Nutrition
SWCD	Social Welfare and Community Development
TBA	Traditional Birth Attendant
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organisation
WNCC	Ward Nutrition Coordinating Committee

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Executive Summary

This report presents the findings for the first stage of the 1000 Most Critical Days Programme process evaluation. The National Food and Nutrition Commission (NFNC), in coordination with several donors, including the Department for International Development (DFID, developed a bundled, multisector programme called The First 1000 Most Critical Days (MCDP) in order to address Zambia's child undernutrition. CARE, in conjunction with the NFNC, coordinates the implementation and delivery of the programme through several ministries. American Institutes for Research (AIR) was contracted by DFID Zambia in 2014 to conduct a two-year evaluation of the MCDP. The evaluation includes three components: a rapid qualitative assessment, a process evaluation, and an impact evaluation. This report presents the findings from the first process evaluation study, with a focus on implementation experiences, including communication and coordination, monitoring and reporting, financial flows, and successes and challenges in implementing each of the MCDP priority intervention areas.

In both Chipata and Mbala, we found that higher (District, WNCC) levels of actors had a good conceptual understanding of the implications of the multisectoral paradigm and co-ordinated approaches to implementation. This understanding diminished, however, further down the programme chain. Furthermore, although some coordination in activity planning and implementation (chiefly in the area of sensitisation) was under way (particularly in Mbala), this was limited by the overall slowness of activity roll-out. In terms of planning and communication, we found challenges particularly along the vertical axis, in particular between the WNCCs and their respective DNCCs: In both districts, WNCC members felt that they did not have particularly good communication with their DNCCs and that their role had been limited to simply carrying out the orders of the DNCC. We heard calls for greater ownership and autonomy. Finally, moving up a level, we note that line ministry focal points on the DNCC in Chipata reported poor communications with CARE, in which repeated requests for funding carry-over went unanswered.

Respondents we spoke to at the central, district, and ward levels indicated that monitoring processes are not being consistently or systematically carried out. Although a new, harmonised monitoring and evaluation plan was recently created, it is not yet operational. Because a unified monitoring tool for the MCDP is lacking, programme implementers improvise to extract relevant data from their respective line ministries to monitor activities. Using existing ministry registries creates an additional burden for those responsible with the task of reporting. Although the programme targets and would therefore report only on children of ages 0–2, ministry registries focus on children 0–5 years old, meaning MCDP staff must spend time extracting only the children of ages 0–2 from the registries. Furthermore, confusion over which activities are SUN-funded and which would occur without the MCDP continues to be a challenge for reporting. The lack of clarity in which activities can be attributed to the programme raises reliability problems in what is reported.

Financial processes and the flow of funds pose perhaps the most significant obstacle to MCDP implementation. There appears to be a fundamental mistrust of accountability over finances between the central, district, and ward levels, causing significant challenges in communication and coordination of financial reporting and approval procedures. Delays in funding

disbursements pose substantial problems to implementation of several intervention activities which are time-sensitive, reducing their effectiveness. In addition, when districts need to 'carry over' funding from one quarter to another, the procedures necessary to request this approval cause further delays on interventions. Inconsistent funding also causes programming gaps, leading many to forget earlier activities which they may have been a part of, ultimately preventing MCDP processes from being institutionalised by implementers.

Findings highlighted many successes and ongoing challenges experienced by implementers delivering the programme's priority interventions. In Chipata, IFA, vitamin A, and deworming activities occur regularly, and respondents noted that they have sufficient tablets to distribute. Most respondents felt that SUN funds had not significantly added to existing IFA, Vitamin A, and deworming activities, though some explained that the MCDP has been successful in routinising the activities. MCDP activities in breastfeeding also have systematised a focus on appropriate breastfeeding practices. In Chipata, a separate breastfeeding mothers' group has been established, and sensitisation occurs frequently with pregnant women to encourage and educate them on feeding. Respondents in Mbala reported a shift in dialogue about child feeding as a result of the MCDP. Some respondents we spoke with in Chipata described a training they had received on IYCF, explaining how valuable it was, but others within the same ward revealed they had not yet had an opportunity to attend this training, highlighting perhaps inconsistent targeting efforts for trainings. Resource challenges also were mentioned by ward-level MCDP implementers, who expressed a need for additional resources, particularly for cooking demonstrations and community training activities.

Respondents provided mixed opinions on the ways in which the MCDP has added to growth-monitoring activities. Though plans exist to train growth promoters and growth monitoring volunteers, trainings have not occurred in either district as a result of funding constraints. In addition, in Chipata, insufficient growth monitoring and IMAM inputs have been provided, causing problems with conducting adequate sensitisation to malnutrition and inhibiting growth-monitoring activities. At the same time, in Chipata, implementers emphasised that because of the MCDP, they sensitise a great deal more on stunting, and pregnant and breastfeeding women consequently understand the link between malnutrition and stunting.

A number of SUN activities in dietary diversity have been completed in Chipata and Mbala. Respondents mentioned several sensitisation activities which have been integrated into regular ministry functions, as well as cooking demonstrations in Mbala, both of which target farmers and women's groups. Respondents in Chipata reported more challenges in carrying out activities because of a lack of funding, and the trainings which have been provided were reported as too superficial. In contrast, in Mbala, the district office has conducted training and multiple cooking demonstrations, and by conducting fewer and targeted trainings they managed to distribute agricultural inputs systematically.

We also found significant variations between the districts in WASH activities, likely because Mbala is already a pilot district for a Ministry of Education and UNICEF-funded community-led total sanitation intervention. In Chipata, this intervention area largely focused on chlorination of wells and orientation of pump menders, and in Mbala activities served to reinforce previous activities done under the UNICEF CLTS project. WASH activities require substantial coordination between multiple ministries and other NGOs conducting relevant activities.

Although it is too early to assess the success of ministerial coordination, respondents indicated that the MCDP has not been in contact with other NGOs to ensure that efforts are appropriately targeted and not duplicated.

Although community sensitisation to MCDP priority intervention areas is ongoing, the rollout of formalised nutrition messaging is still limited. The IEC materials which respondents did mention had been developed centrally and were in English, and consequently not as effective as they could have been because the target recipients of these materials do not read English. Respondents expressed a clear need for tailored messaging appropriate to the localised traditions and customs which perpetuate poor IYCF practices.

Summary of recommendations for action

- Clarify roles and responsibilities of all actors at all levels of the programme.
- Create an information sharing mechanism so that the various ministries and coordinating bodies can effectively coordinate with one another, communication lines are open, and the programme is transparent.
- Vertical communication, in particular between district (DNCC) and ward (WNCC) levels is currently perceived as problematic. Consider ways of improving this situation: provide funding for more regular meetings and DNCC field trips and ensure that WNCCs receive more regular and complete briefings from the DNCCs.
- Seek ways to foster greater WNCC ownership of the programme activities. WNCCs desire greater autonomy; although this may not be practical, involving WNCCs more actively in activity planning would help to engender empowerment through participation.
- Consider standardising WNCC structures and composition, as well as the possibility of assigning the leadership role to a member of the health cadre.
- Formalise regular training opportunities in financial management for anyone responsible for these processes and institute practical exercises for these individuals to build their skills interactively. This will ensure that those responsible for funding requests, which are critical to programme delivery, may develop the skills necessary to keep the programme moving.
- Train on proper monitoring procedures—on data collection, tools, and reporting.
- Submit only consolidated reports from the DNCC, reducing the confusion and inconsistencies inherent in individual line ministry reporting.
- Develop a system which is less complex than extracting information from separate line ministries—it is time consuming and error-prone.
- Provide on-the-ground mentoring on planning, budgeting, and monitoring.

- Include a specific emphasis on documenting and evaluating the new M&E system during the process evaluation to be conducted in October 2016. The longer term recommendation is to adopt a unified and community-based system of data collection with community workers and implementers as data collectors and using mobile platforms to create dashboards and real-time information for both implementers and policymakers. We consider it important to integrate as much as possible of the SUN M&E platform into DHIA2 or a similar tool.
- Consider placing responsibility for carry-over approval decisions in the hands of the DNCC, or at the provincial level, rather than the national level, with the aim of streamlining the process and improving the flow of finances.
- Consider making an administration budget line more accessible to the DNCCs.
- Consider restructuring to create greater separation between the technical assistance and the financial dimensions of the programme, and also assess the possibility of offering more direct funding channels to DNCCs.
- Minimise incomplete interventions, such as training pump minders without subsequently providing borehole spares.
- In the event of funding constraints, consider a more complete roll-out in a smaller number of wards (as done in Mbala), rather than an incomplete roll-out in many wards.
- Clearly define the transition from training to action, and make every effort to minimise the gap between the two.
- Clarify procedures for carrying out sensitisation, and promote greater standardisation generally. We are not recommending that every ward carries out a given activity in the same exact way, but we are recommending common guidelines and the need for operating procedures. We recommend support in defining delivery mode and all implementation procedures and in developing written procedures for each activity.

Introduction and Background

American Institutes for Research (AIR) and Palm Associates Limited (PAL) were awarded a Department for International Development (DFID) contract to provide services to design and conduct a mixed-methods evaluation of The First 1000 Most Critical Days Programme (MCDP) to help design the implementation of the programme, to determine how the programme should be scaled up, and to assess the effects of the bundled nutrition interventions on health and nutrition outcomes. AIR and PAL's mission to conduct and apply the best behavioural and social science research and evaluation toward improving people's lives, with a special emphasis on the disadvantaged, closely aligns with this project and with DFID's goals.

Worldwide between 1990 and 2011, the incidence of stunting has been reduced by only 2.1 percent per year on average (UNICEF, WHO, & World Bank, 2012) despite significant progress in the delivery of individual interventions (Gillespie et al., 2013). Delivering individual interventions is thus not adequate to reach the Millennium Development Goal of halving the number of people who suffer from hunger. MCDP aims to deliver a package of nutrition interventions, which can bring important synergies, but there is only limited evidence on how to cost-effectively deliver and scale a package of nutrition interventions. For example, delivery strategies are crucial but there is not yet enough evidence to show whether financial incentives or community-based interventions work better to improve nutritional outcomes (Bhutta et al., 2013). This evaluation will make an important contribution to the limited body of evidence on bundled nutrition interventions.

Undernutrition is one of the most serious global health problems. Stunting, wasting, and micronutrient deficiencies contribute to nearly 3.1 million child deaths annually (Bhutta et al., 2013). In Zambia, half the deaths of children under the age of 5 are attributed to maternal and child undernutrition. According to the most recent Demographic and Health Survey in Zambia (2007), 45 percent of the under-5 population is stunted. This statistic amounts to 1 million children. Malnutrition, including iodine deficiency and inadequate vitamin intake, leads to decreases in cognition because the development of the brain is vulnerable to inadequate nutrition (Bardham, Macours, & Maluccio, 2013). Evidence from Kenya further shows that malnutrition can result in decreases in school enrolment (Miguel & Kremer, 2004) and subsequent losses in labour productivity (Baird, Hicks, Kremer, & Miguel, 2011). The economic benefits of a healthier population are large: during a 10-year period, Zambia could increase economic productivity by $1.5 billion with just a 1 percentage point per year decrease in stunting, a reduction of maternal anaemia by one third, and elimination of iodine deficiency (NFNC, 2011). The consequences of malnutrition are particularly severe during children's first 1000 days of life (Almond & Currie, 2010).

The First 1000 Most Critical Days Programme

The National Food and Nutrition Commission (NFNC), in coordination with donors, including DFID, developed a bundled, multisectoral programme called The First 1000 Most Critical Days Programme (First 1000 MCDP, or simply MCDP in this report), in order to address Zambia's child undernutrition, with CARE International as the implementing agency. The programme involves several ministries, including the Ministry of Health (MoH), the Ministry of Agriculture

(MOA), the Ministry of Community Development, Mother and Child Health (MCDMCH), the Ministry of Education, Science, Vocational Training, and Early Education (MSVTEE), and the Ministry of Local Government and Housing (MLGH). The multisectoral approach draws on NFNC's leadership and the promises made by Zambia in signing the Scaling Up Nutrition (SUN) initiative. The three-year intervention was scheduled to begin in 2012 and will run through 2015.

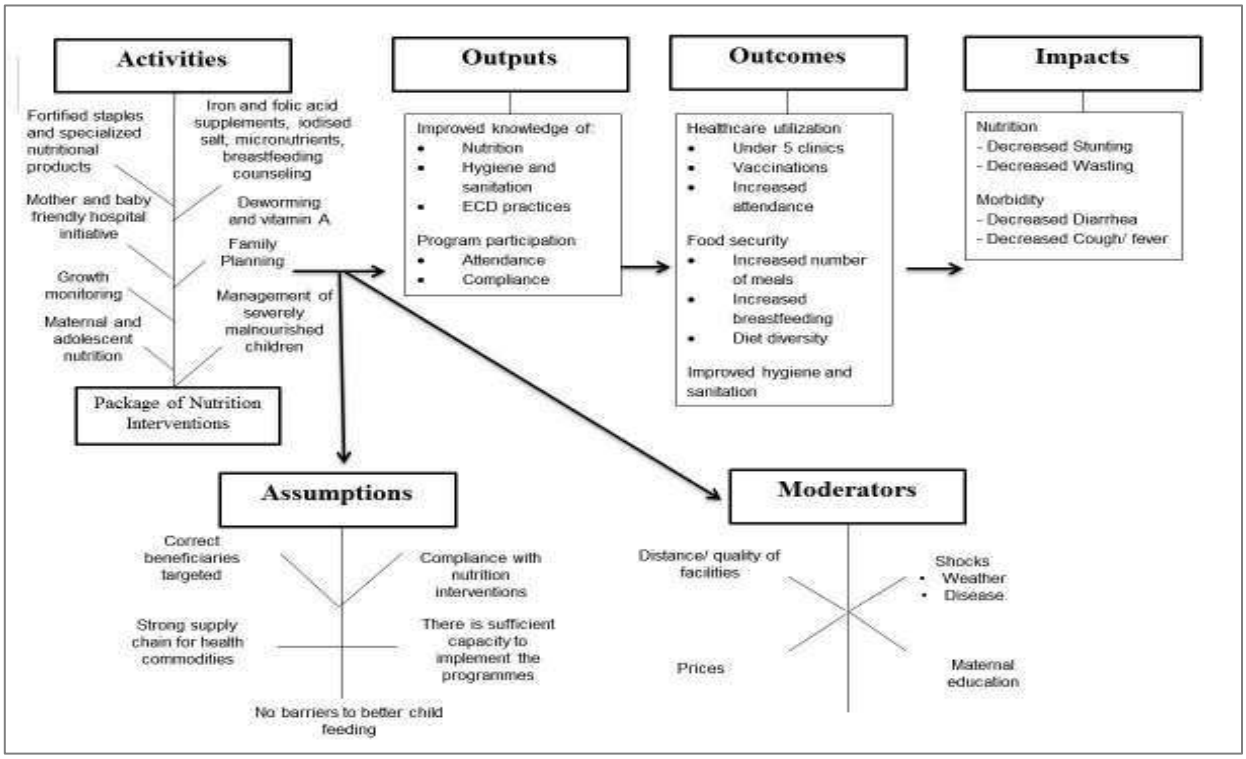
The programme targets households with children under 24 months of age and includes a package of activities and supports that will focus on maternal and adolescent nutrition; deworming and vitamin A supplementation; family planning; growth monitoring; iron and folic acid supplementation; iodised salt, micronutrients, and breastfeeding; fortified staples and specialised nutritional products; a mother- and baby-friendly hospital initiative; and management of severely malnourished children (National Food and Nutrition Commission of Zambia, 2011). The First 1000 MCDP will be implemented in 14 districts: Mumbwa in Central Province; Chipata and Lundazi in Eastern Province; Mansa and Samfya in Luapula Province; Chinsali in Muchinga Province; Kaputa, Kasama, and Mbala in Northern Province; Zambezi in North-Western Province; and Mongu, Kalabo, and Shang'ombo in Western Province.

Theory of change

AIR and PAL believe that policy-relevant research should be built on a theory of change which maps out the causal chain between activities, outputs, outcomes, and impacts, as well as the assumptions underlying the theory of change. We developed a theory of change to motivate our study design.

CARE and the relevant government ministries are implementing a package of nutrition activities to poor households with pregnant women or newborn children living in rural areas. The ultimate goal of the intervention is to improve nutrition and reduce morbidity amongst children during their first 1000 days of life. The theory of change depicted in the figure which follows maps out the causal path between the activities and the ultimate goals of the programme listed as impacts. We hypothesise that, for the programme to realise its goals, it will need to be implemented with fidelity, will need to increase parental knowledge of nutrition and services available, and will need to change actual feeding practices. We will measure indicators and collect data at each step of the causal chain to provide a formative and summative evaluation which explores what works and what needs improvement, and which can be used to continuously adjust the programme design and implementation. Sociological and health theories of nutrition suggest that the impact of nutritional interventions may be weaker or stronger depending on local conditions in the community or household. We will look at factors which may moderate the impact of the program, such as access to services and facilities, mother's education, and local economic conditions.

Figure 1. Theory of change



Process evaluation

Process evaluations focus on implementation and uptake and help us to understand the fidelity of a given programme's implementation in order to learn whether the delivery of the programme has deviated from the original plan and how deviations might affect costs and impacts. Process evaluations also help in understanding how to reproduce the programme in other contexts and provides evidence, knowledge, and lessons about implementation and design. For these reasons, a process evaluation is very much 'action research'. The overall process evaluation will include quantitative and qualitative methods, as well as direct observations and collection of programmatic data. It is divided into two components: the first of these, upon which the current report is based, is focused principally on supply-side issues and employed qualitative approaches to gather information on programme roll-out and implementation. Key topics for this component were documentation of implementation activities status, including not only what and where, but also how, the activities are implemented. We highlight challenges and bottlenecks but also positive findings which can inform future implementation. We also flag possible inefficiencies in running the programme. The second part of the process evaluation, to be carried out later in 2016, will address implementation in addition but, in keeping with the programme's maturity at that point, will bring in quantitative methods to assess programmatic data and other supply-side programme delivery issues. In the second component, we will carry out interviews with beneficiaries in order to gain a better understanding of programme uptake, or demand-side questions.

Methods

Data collection

The overall data collection approach in this component of the process evaluation is qualitative. Qualitative work makes a central contribution to process evaluation because it allows us to explore the reasons that a given link in the theory of change is not working optimally. In process evaluation, it is never sufficient to simply identify elements which are underperforming; in order to improve programme design, we need to understand why elements or linkages work or do not work. We need, in other words, to open the black box. Qualitative approaches, characterised by in-depth interviewing techniques and open-ended questioning, seek to reveal the reasons and logic which underlie a programme's implementation and uptake performance.

We employed key informant interviews (KIIs) and focus group discussions in this component of the process evaluation. We interviewed key informants (particularly those involved in service provision) principally to elicit opinions about programme implementation. In these interviews we used a semistructured interview guide, focusing closely on topics pertinent to each category of key informant and allowing scope for probing and exploration of themes emerging from different responses. Focus group discussions, also based on tailored guides, were carried out with health and nutrition staff and implementing actors throughout the programme chain from district to ward, health facility, and community. In addition, focus group discussions were carried out with agricultural and women's groups (in order to collect some early uptake data). Focus group discussions, when well implemented with an appropriate group of participants, can be especially useful for collecting a substantial amount of data in a relatively short time.

Research sites and informants

As described in the Inception Report, data for the process evaluation was collected only in the intervention wards of Chipata and Mbala districts which were chosen for this evaluation component. In consultation with stakeholders, it was decided to collect data in the same Chipata wards where the Rapid Qualitative Assessment was carried out in 2014, Nsingo and Nthope. Within these wards, the research team visited four health facilities, one school, and four agricultural camps. In order to optimise the use of time and resources, the research team, in consultation with DFID, decided not to replicate the entire Chipata data collection in Mbala, but instead to carry out a more targeted and concise data collection exercise in that district, principally for the purposes of triangulation and comparison. It is therefore important to bear the following in mind when reading the report: The bulk of the interview and focus group discussion data referred to are from Chipata. We draw Mbala findings in when they constituted relevant learning points of either congruence or contrast. Data was collected in Lusaka and Chipata in March and April 2016 and in Mbala in May 2016. Data collection methods and samples are summarised in Table 1.

Table 1: Research sites, methods, and informants

Site	FGD	KII
Lusaka		CARE staff, NFNC staff
Chipata District	DNCC MOA, DNCC SWCD, WNCC	DCNN co-ordinator, DNCC MLG, DNCC MOH
Chipata, Nsingo Ward	1 FGD with nutrition champions	12 health and nutrition personnel interviews with CHV, GMP, SMAG, in-charge, nutrition champions, TBA. One KII with school staff
Chipata, Nthope Ward	6 health and nutrition personnel FGDs with CHV, CHW, GMP, SMAG, nutrition champions, Breastfeeding Committee members. 2 beneficiary FGDs with Lead Farmers and Women's Group	9 KIIs with health and nutrition staff including: WNCC members, in-charge, CHV, EHT, SMAG, GMP, CHW
Chipata, Luangeni Camp	SUN Lead Farmers (1) SUN Women's Group (1)	
Chipata, Mwasha Camp	SUN Lead Farmers (1) SUN Women's Group (1)	
Chipata, Kanyanja Camp	Observation of agricultural training	
Chipata, Mzoole Camp	Lead Farmers (1) Women's Group (1)	
Mbala	DNCC, WNCC	5 KIIs with DNCC line ministry focal points
Mbala	Observation of fish ponds and vegetable farms	

Data handling

We carried out data collection by employing two-person teams in each activity. Wherever possible, one field researcher was responsible for interviewing or facilitating and the second researcher had primary responsibility for recording responses. Researchers noted responses (in local languages where necessary, but generally in English) in notebooks, and they recorded all interviews, together with FGDs, on portable digital recorders. Researchers downloaded these recordings to field laptops each day, renamed them according to an anonymised code system held in an encrypted Excel sheet, and then copied them to external media for backup. The field researchers transcribed the recordings and handwritten field recording sheets to Microsoft Word documents, translating the material where necessary. All transcriptions also were assigned new names (in accordance with the code system) in order to ensure data and informant confidentiality.

Coding and analysis

Lead researchers developed a descriptive coding scheme linked to an overall analytical framework, with specific reference to themes of interest and research questions. The researchers then loaded the coding scheme and the transcripts into the qualitative data analysis (QDA)

software package (NVivo Pro). Coding in NVivo is a manual process based upon careful reading of each piece of data (in this case, interview responses and other notes) and subsequent selection of appropriate code(s) to describe these data. Once properly coded, the data can be analysed in different ways prior to producing written outputs.

Ethical clearance

Ethical clearance was obtained from the review boards of AIR and the University of Zambia (UNZA).

Research Findings

Structure and Organisation

In this section we address the related issues of coordination, planning and harmonisation, communications, and support systems. One of the most innovative features—at least in the Zambian context—of the MCDP is its multisectoral nature, involving line ministries working together to provide truly cross-platform implementation of priority interventions. It is important, when reading this section, that we bear in mind the fact that whilst 'multisectoral' and 'cross-sectoral' refer to a horizontal model of coordination amongst implementing ministries, vertical coordination and communication also are of critical importance to the MCDP. In other words, we also must consider coordination and communication down the programme chain, from Lusaka to District level and further to ward, health facility, agricultural camp, and community level.

Coordination and planning

Understandings of coordination and the cross-sectoral model

> 'Personally I think the advantage I see with the multisectoral approach, I really believe, is the fact that when everyone focuses all their efforts on this community there will be an impact. That is for sure because we know that if that community is challenged in terms of water and sanitation and hygiene, and then you pump in all the agriculture and you pump in all the other aspects, you will still have a problem because diarrheal diseases will be a challenge for that community. So the impact is the only thing that we do know that is a very big advantage of this multisectoral approach.' (interview with NFNC nutritionist and food scientist)

> 'This is new for us, it is the first time we have signed a huge program focused on different sectors working together. That earlier on was one of the challenges. Different sectors *didn't understand because they* were so used to working in silos and you know each institution has its own culture which focuses on how they bind themselves together and how they move. So with the coming of the SUN program which has the multisectoral approach it means actually that a sector now has two sides. They have to abide by their own mandate but that mandate is also supposed to be married to the nutrition aspect which the SUN is propagating.' (interview with chair of Chipata DNCC)

The coordinated, multisectoral model of delivering priority interventions is well understood at district level in Chipata: line ministry focal points on the DNCC were very conscious of the

model and of the fact that it represents a new model of working, in contrast to the previous 'silo' approach, in which interventions were not cross-sectoral but were instead delivered by individual ministries: *'*We have been working with the district in a silo but the only difference is that now we are working as a multisectoral team, we are incorporating everything so that we target the same beneficiaries in all of the sectors unlike in the past where usually we concentrated only on our own thing*'* (FGD with MOA, Chipata). As this quotation indicates, 'coordination' is understood not only as a collaborative mechanism for delivery and planning of multisectoral interventions but also as a targeting paradigm: before the arrival of the MCDP, a given person or household might have been eligible for some (governmental or nongovernmental) interventions and not others, the programme has, in theory at least, brought some degree of consistency to the selection process. Now, ideally, the relevant priority interventions should 'converge' on a common population of beneficiaries identified by a consistent metric.

There also is a strong recognition amongst line ministry members of the Chipata DNCC that the principal difference between the MCDP delivery system and previous ones is not related to the types of intervention per se, but rather to the multisectoral and coordinated delivery model promoted by the programme. In other words, there is a solid awareness that the interventions themselves are largely not new but that they are now supposed to be delivered in a manner which reflects intensification and institutional strengthening as well as collaboration between relevant line ministries.

Although awareness and understanding of the multisectoral model and the need for coordination are high amongst DNCC members, these informants also emphasised that in practice, coordination was more challenging than in theory. In one FGD with MOH personnel in Chipata, it was observed that *'*Most of the activities that we have done are training and sensitisation*'*. This point also is related to the problem of funding flows, which is discussed later in this report. Nonetheless, it is important to mention it here too: in the context of erratic funding disbursements, in which different ministries have received funding disbursements at different times, coordinating activities multisectorally can be especially challenging when partners may not have access to the same resources at the same time. This point was made in an FGD carried out with personnel from Social Welfare and Community Development: *'*Of course explaining to the departments [that] it is now multisectoral and we need to work together, it has not been very easy, because some of the departments have been so resistant. Because when they are funded as a department (they may want to maintain their budget lines), because even if we are working together each key line ministry is receiving funds on their own. Like health on its own and agriculture on its own. So now when it comes to implementing activities together, it has*n't been* easy because when they get their funds some will just and start implementing without even informing the DNCC*'*.

A further challenge to achieving successful coordination across sectors is the problem of overlapping mandates and territories: 'So that overlap of mandate is at times the one that brings conflict in roles because one would feel this is my role and not for the other department and that has not been or like has been mentioned. Because if you say you want to reach the communities or you want to provide alternative livelihood then the other department is also doing that' (FGD with SWCD, Chipata DNCC). In this FGD, the example of growth monitoring was mentioned to emphasise this issue: although the Department of Social Welfare and Community Development felt that they had a role to play in promoting growth monitoring in communities, their staff felt

that they had been pushed to the margins by the Ministry of Health, whose personnel felt that this area should come exclusively under Health. It is important to note a contrast here, with an opinion expressed by NFNC staff in Lusaka, who cast the issue of overlapping mandates in a more positive light, arguing that they could be viewed as creating greater redundancy in implementation, leading to greater impact amongst the common target population.

At the ward level, in Chipata, there also is a strong awareness and understanding of the coordination paradigm: the WNCC (Ward Nutrition Coordinating Committee) is mandated to lead the coordination process in implementation of priority interventions, and its members are in general conscious of the approach. That said, understanding of the model begins to tail off as we move to health facility level or community-level coordination. Some farmers' groups, for example, simply were not aware of the WNCC, in spite of the fact that these groups represent key targets for the supposedly coordinated activities of the MOA and Social Welfare/Community Development. We should note that at the health facility level, there was greater understanding of the approach amongst higher level technical staff, such as EHTs. The EHT from Nthope Ward in Chipata made the point that although some coordination took place before the arrival of the MCDP, this was largely related to logistics, whereas now, with the advent of the programme, both targeting and messaging are coordinated.

It is worth noting here that although overall, at least down to the level of the WNCC, understanding of the multisectoral approach is generally good, the precise details and implications of the approach do not always align with their interpretation at higher levels. In an interview with the food scientist and a nutritionist at the NFNC in Lusaka, the point was made that the concept of coordination is not always correctly understood at district (and presumably ward) level. This is illustrated in the following quote, which, although lengthy, we reproduce in full because it is particularly informative, offering a more nuanced interpretation of the mandate:

> *'*Yes, even though sometimes you do get the impression that there is some bit of *misunderstanding when you say "going in together as a team". There is this* misunderstanding that every time you have to carry everyone along and we are trying to emphasise that that is not what we mean. What we mean is (that) it is possible that you go *into the same community, you "speak one language". Agriculture could have gone there,* they would have spoken so much and tackled maybe a bit of health here and there (using) whatever information they have been given. But when health goes, they should also speak the same language to the same community so that they know that it is not only a matter of people going as a team, it is also a matter of how you handle issues when you are there as an entity. That the multisectoral approach does not mean every time the whole DNCC, *because we are getting concerned, there was this approach which was coming up "oh* yes, you are saying we should be going multi-sectoral approach, so we should all be *going"*. We said no, that is not the idea, sometimes you might only be the two of you, sometimes the three of you, sometimes even a single sector. But the idea is how you give that information to show that you are working as a team and you are not working alone*'* (interview with NFNC nutritionist and food scientist).

Mbala shares some of the same difficulties in achieving coordination because of the unharmonised funding disbursements to line ministries, but the coordination model has been pushed farther along the programme chain than was found to be the case in Chipata. In part, this

result may be simply because implementation generally is more advanced in Mbala than in Chipata, allowing the different line ministries to engage more actively in coordinated implementation of priority interventions. That said, we also should note that, as was found in Chipata, coordination was most successful in sensitisation activities. Coordination was said to be particularly active during Child Health Week, during which both the MOA and the MOH were involved. Mbala also was the site of an innovative collaboration in which the MOA was brought into the implementation of WASH activities (which are normally coordinated by the Ministry of Local Government and the Ministry of Education). The MOA was involved in ensuring that the water points established as part of the WASH programme also were located in the vicinity of productive gardens.

Planning

An important dimension of coordination is the planning of activities. As just discussed in relation to overall understanding of the coordination model, coordinated activity planning is generally seen as welcome and feasible at the district level, although we should note that CARE staff interviewed on the subject were more guarded in their assessment of coordinated planning carried out at the district level, noting that at times district plans were overambitious, unrealistic, or insufficiently engaged with community uptake. CARE in fact has launched a review activity in order to make district-created plans 'more realistic'. Again, as discussed, coordinated planning is put most intensively into practice at the district level, declining in intensity as we move down the programme chain to ward level. CARE staff members were keen to emphasise this point, noting that planning tends to be too focused at the district level and often fails to engage communities in the process.

These sentiments were echoed by FGD participants from the Chipata WNCC, who felt that there was a strong vertical disconnection between planners and implementers. They felt that they had to a greater or lesser degree been relegated to a lower status of simple implementers, mandated only to carry out the plans made by the DNCC: one participant in this FGD noted, 'activities are planned by DNCC, then we (WNCC) just help implementing. We get the plan late from DNCC, *when the term is ending. There's only 5 days remaining and we have to jam together the* activities and we do them badly. Other times we have a proposal of what we want to do, but unless it is part of the specific work plan from the DNCC, that activity will not get funded. This discourages planning. We do not have idea of the activities in the work plan until too late, and also we do not have an overall work plan fro*m DNCC so we don't know what activities* specifically the DNCC has planned for SUN for the entire period*'*. The WNCC personnel felt that they should have a much greater role in planning activities related to the priority interventions; such involvement, moreover, would help to ensure that activities planned were relevant to the communities where they were being implemented. These feelings were mirrored in Mbala, where the WNCC members also felt that they needed more autonomy and ownership of planning activities.

Communications and support systems

Closely related to the questions of coordination and planning is the issue of communication. In this case, we are focusing particularly on vertical communications because horizontal communications, for example amongst the line ministries working in the DNCC, or amongst

various delivery actors and institutions at ward, health centre, or community level, were found to be less problematic. DNCCs, for example, meet regularly, and the chair of the DNCC is responsible for ensuring coordination between the line ministries comprising the body.

Vertical communications present challenges in the MCDP. This appears to be true up and down the programme chain. CARE personnel, interviewed on this topic, observed that they needed to strengthen communications with NFNC; meanwhile, in a focus group discussion with DNCC Ministry of Agriculture personnel, it was emphasised that communications with CARE, particularly related to carry-over of funding from one quarter to the next, were very problematic:

> *Response…we wrote a request to CARE to carry over the funds, sometimes to vary (carry* over) the funds so we so the activities that are required to do but there was no response *from CARE they would just keep quiet so we didn't know what was hap*pening, we had to just wait we made some follow ups but it was just quiet.
>
> Interviewer: How many of these requests did you make?
>
> Response: Hmm. It must be more than two or three because I remember the first request that we submitted to CARE was after we received the funds in September, we requested to carry over the funds to the fourth quarter because the third had already ended. There was no response so after we realised that we were getting to the rainy season so thought to vary the funds we wrote a letter to CARE to vary the funds so that instead of using the training we could procure seeds but there was no response then recently we wrote another request after the fourth quarter ended so that we could carry over the funds to the first quarter but again no response.

In Chipata, the WNCC members expressed views essentially parallel to their position on planning already discussed. That is to say, there is a sense of being cut off and not having a truly open communication channel with the DNCC. Although review meetings are held quarterly, the WNCC focus group participants felt that although they had communicated challenges and concerns to the DNCC, the DNCC had not been as responsive as it should have been. Moving even further down the programme chain, we note that although health facility staff are generally in contact with WNCC members who help to coordinate their activities, programme beneficiaries at the agriculture camp level generally had minimal contact with programme entities other than agricultural extension workers.

In Mbala, as in Chipata, there also is a perceived disconnection in vertical communications between the WNCC and the DNCC. WNCC members reported that they felt out of touch with implementation activities at the ward level and expressed concern at not really having access to a full picture of implementation even at their own ward level. Members of the Mbala WNCC expressed their frustration at being excluded from the MCDP. They explained that because of a lack of communication with the DNCC, they are not aware or informed of MCDP activities taking place in their ward, with the exception of overseeing the use of MCDP bicycles. Because the WNCC is a product of the MCDP, the fact that it is not being integrated into programme processes presents problems, in that it indicates that the programme is not being coordinated or managed according to plan. The WNCC is responsible for reporting on MCDP activities; consequently, bypassing the WNCC in programme implementation and communication has an impact on the quality of reporting which takes place in this district.

Monitoring, Planning, and Reporting

At the time of the process evaluation, monitoring of the MCDP had yet to become institutionalised and carried out consistently, though the research team is aware that activities are underway to address this issue. Though it took a year to complete, NFNC now has an M&E plan which was finalised in both evaluation districts and which was on track for being operational starting from quarter 3 of 2016. In addition, an M&E technical group exists, which comprises focal points from ministries at the national level and also includes the WHO and NFNC. The M&E technical group revised the MCDP log frame and aligned it with a First 1000 Days M&E Plan. One respondent at CARE explained that this common log frame was shared with the teams that travelled to the MCDP districts to review monitoring plans. The final plan was completed after integrating comments from the districts and after testing it. This new M&E plan should inform and assist future monitoring efforts by providing standardised indicators to collect data on programme implementation. Before the M&E plan is fully operational, however, full training and testing will be necessary at the community level, where most implementers seemed to be unaware of the upcoming M&E plan. At the time of data collection, MCDP implementers at the community, WNCC, and DNCC levels described a range of challenges they face when fulfilling monitoring responsibilities. In this section, we discuss M&E training, current monitoring activities, M&E reporting processes, and overarching challenges to programme monitoring.

Training

At the time of the field interviews, respondents in Chipata had not yet received training on how to effectively monitor MCDP activities. One member of the Chipata DNCC explained 'we have not been trained per se but we have been doing it from the knowledge that we have'. Respondents clearly expressed the need for training on monitoring and how to collect relevant data, and also requested a set of monitoring tools which can be used to do so. Whilst the research team was in the field, the MCDP began a training for the Chipata DNCC on monitoring and evaluation. We hope that MCDP activities will prove useful and alleviate many of the concerns expressed by respondents about their capacity to fulfil these essential responsibilities. In Mbala, a workshop on monitoring and evaluation had recently taken place for the DNCC; although new indicators had been discussed during this visit, however, the Mbala DNCC did not yet have a copy of the final set of indicators and explained that the indicators were being updated after receiving feedback from all districts.

Monitoring activities

Because, at the time of evaluation, no single M&E system existed for the programme, implementers were tapping into existing data collection systems from their own line ministries to extract information. These information systems used for routine activities often were informal and not properly recorded in one synthesised document. Not all districts had a proper information officer dedicated to M&E. The District Health Office information officer sometimes took the lead in providing data necessary to complete reports or to take decisions about targeting. The checking and quality assurance systems were based on individual visits from district officers who were conducting random visits and interviews from beneficiaries. No unified checkbox or data collection tool was provided. When we approached the district offices for collecting

monitoring data, we found only isolated and often improvised attempts to collect information. Reports of activities were done in a descriptive way through activity reports stored in folders with each district (Mbala) and only material goods (bicycles, agricultural inputs) were well tracked with signature sheets (in Mbala and Chipata). Other activities, such as trainings, were recorded only for attendance records and for retirement purposes. There was no unifying tool for recording data on activities of any kind except for the report template.

The respondents also highlighted a need for support in this area and acknowledged the monitoring system to be inadequate for the needs of 1000 MCDP. Some examples are the challenges described later in this report, such as the inability of the current Ministry of Health reporting system to capture information on children under 2 specifically (as opposed to the under-5 children traditionally tracked by the MOH) or the lack of specific definition of roles and responsibilities in collecting the data. One respondent from CARE explained that consequently 'the extent to which that data [are] actually representing the actual situation is questionable'. Another explained that, in terms of monitoring, 'currently we are running up and down', emphasising the need which many expressed for a standardised tool to collect data.

In Chipata, respondents discussed monitoring in terms of tallying and ensuring that numbers of recipients of a particular service are recorded in the corresponding registers. One respondent at the Chipata DNCC explained that their monitoring procedures consist of verification, '*that's why* we go to verify to see that what is actually in the report is what is happening in the ground'. A member of the Mbala DNCC explained that often things are based in the community, but they will go to communities to complete spot checks and monitor specific tasks such as ensuring that MCDP-provided bicycles are being put to good use. Members of a WNCC in Chipata, for example, understood their monitoring responsibilities, but one indicated that they face challenges in fulfilling them consistently: 'transport is our problem. We seem to be the mother body but now to monitor the activities of these [nutrition] champions, we cannot manage'.

The one exception are MLG activities for Mbala, which are attached to the DHIS2 mobile system. The MLG used information from DHIS2 to plan activities and decide which villages needed to be prioritised in boreholes mending and to monitor progress in CLTS. The district is using DHIS2 as part of the UNICEF CLTS pilot, but the information was easily synthesised for reporting purposes as well.

The hope is that the new M&E system has solved this situation of uncertainty and lack of documentation and knowledge with a systematic, feasible, and sustainable M&E system. The short-term recommendation is to include a specific emphasis on documenting and evaluating the new M&E system during the process evaluation to be conducted in October 2016. The longer term recommendation is to adopt a unified and community-based system of data collection with community workers and implementers as data collectors and using mobile platforms to create dashboards and real-time information to both implementers and policymakers. Therefore, we consider it important to integrate as much as possible of the SUN M&E platform into DHIS2 or a similar tool.

Planning and operating procedures

Our visit also highlighted the need for support in compiling operating procedures for each of the activities in the work plan. The activities in the work plan are laid out in an orderly and logically consistent way, but this order and correspondence was not fleshed out into its details and composed into a process of conducting these activities. There is no written trace of the how, where, and when components of planning these activities. The respondents mentioned that these details are communicated directly to the DNCC coordinator and during the DNCC meetings and that they are then transcribed into the implementation plans. The implementation plans, however, do not have the necessary level of detail to understand the delivery of the intervention. The rationale for choosing certain villages or certain wards is not specified nor who has been consulted, how people have been recruited, who is the target, where the intervention is taking place, and how long it will run. An example of this problem are cooking demonstrations. In Chipata, both the Ministry of Agriculture and Ministry of Health have planned cooking demonstrations. It was unclear, however, how the two cooking demonstrations were planned so not to overlap each other, and details of how were they planned (village, location, recruitment, target, modality) were not specified. This lack of clarity characterised many activities, perhaps partly because these activities had not yet been carried out. Nevertheless, standard procedures are needed even before implementation for ensuring proper budgeting. We are not recommending that every ward carries on an activity in the same exact way necessarily, but we are recommending common guidelines and the need for operating procedures. We recommend support in defining delivery mode and all implementation procedures and in developing written procedures for each activity.

A different issue related to planning is the need for DNCC to have all available data on nutrition at the ward level. According to district personnel, NFNC had spearheaded an initial baseline before SUN started which assessed stunting at the ward level for all wards in Chipata and in Mbala. We could not verify this information at the national level, but the district personnel lamented not having received the results of the NFNC survey. In absence of these data, decisions on how to prioritise wards in Mbala, for example, were based on some 2014 data on percentage of underweight children as a proxy for stunting. The source of these data could not be clearly established.

Activity reporting

The format for quarterly reporting on activities has changed since the beginning of implementation and is set to change again after the new M&E plan is in place. The challenges in reporting are closely connected to the challenges in monitoring because there is nothing to report if activities are not monitored. District officers were confused by the changes in reporting and also confused on some requirements in reporting from the first format, for example, on the ones related to gender-specific activities. The current reports are too imprecise and too descriptive and lead district officers to report activities ‘being completed’ without providing further details.

Overall, respondents consistently noted that monitoring reports for community-level activities are completed at the community level and then submitted to the WNCC, who compile them before submitting them to the DNCC. In Nthope, one respondent described the information they provide to produce reports:

> Reports are on a monthly basis. We send it to the DNCC. We are collecting numbers like how many women have been given folic acid this month, how many women have been given deworming tablets, how many women have been given ferric acid, and vitamin A *for the women, and even on the side of the baby it's just the how many babies weighed.*

Respondents also observed that reporting is based on indicators set by the various ministries involved in the MCDP. One member of a Chipata WNCC described that they extract information from the relevant ministry's registers in each community. The MOH data, however, may not be capturing information for all the activities it is responsible for monitoring. One respondent in the SWCD indicated that although the MCDMCH is grouped with the MOH, monitoring issues are handled primarily by the MOH because they have a planner and M&E officer on their staff. This has resulted in a bias in monitoring primarily health activities at the expense of harmonising monitoring across the areas.

Challenges

Numerous challenges were reported by respondents when they were asked about monitoring processes. CARE identified two principal impediments to monitoring MCDP progress: the lack of an M&E system and a challenge in capacity amongst those who fulfil monitoring and reporting duties at the community level. One respondent from CARE explained an 'absence of a proper data collection system or methodology.… *the way t*he districts are reporting currently does not give you much information*'*. There currently exists no single register which includes all the beneficiaries to be shared amongst the ministries involved in the programme. The lack of a single register creates problems because overestimating the impact of activities by double-counting beneficiaries may result. The lack of a single register also prevents proper coordination and targeting between the ministries. One member of a DNCC explained that 'MOH had their own register and MOA has their own register. But now we are coming up with a register from all of the beneficiaries so that we can all target the same beneficiaries*'*. Until a new system is developed and implemented, monitoring continues to occur through each line ministry, each of which has different reporting lines and structures and does not follow a set SUN template.

One of the biggest monitoring and reporting challenges faced by MCDP implementers is that the programme targets only children of ages 0 to 2, but regular MOH nutrition and health activities focus on children of ages 0 to 5. As previously mentioned, there is no registry which separates MCDP intervention activities from routine processes at the clinic level. Thus clinic staff bear an additional workload of going name by name on a register to extract only the children 0 to 2 years old to report MCDP-specific figures. Though a small number of respondents mentioned instances in which they attempted to record recipients in the SUN target age for specific activities, these efforts were not coordinated or systematic, with one respondent in Mbala stating that they had to improvise in order to monitor according to SUN standards without separate tools. One respondent at the WNCC described this:

> *'It's been* a real challenge to capture the specific children. Those improvisations where you make an initiative, for example, during child health week, where you make a separate sheet to capture the specific age. It is a challenge as capturing is concerned. The one we have as a standard and are using with MOH is not targeted specifically for 1000 Days it's just under 5*'*.

One focus group participant also raised the possibility that data quality may be unreliable, mentioning the probability that staff scrolling through the standard MOH register to extract 0–2-year-old's may miss children. In Mbala, staff at the MOH indicated that they had recently integrated new tools into their reporting system which will assist them in providing MCDP-specific data.

Perhaps the largest challenge to monitoring, which is echoed throughout this report, is that it remains unclear, particularly to community members on the ground who are responsible for collecting information, which activities are SUN-funded and which are standard ministry activities. One respondent from CARE explained that, although implementers do report rich numbers showing, for example, the number of women receiving a given input,

> *'*when we did a data quality assessment we realised that some of those numbers are beyond the wards which are funded by SUN, so they represent an entire district and not necessarily the wards. So they are over reporting*'*.

Additional concerns about the reliability of attributing data to the MCDP were mentioned, and also mentioned was that some data may be reflecting the incorrect age range targeted for the intervention. Several respondents indicated that it is difficult to separate what specifically has changed in the past year in their service delivery and what changes can be identified and tied to the MCDP.

Financial Management and Flow

Adherence to MCDP financial processes is a significant obstacle to effective programme delivery. The line ministries and DNCC complete funding requests and reporting separately. This compounds coordination and communication challenges amongst MCDP stakeholders. The procedures required to process and follow up on funding requests are unclear and time-intensive for community-level implementers. From the perspective of those at the central level, funding gaps are the consequence of poor financial reporting and management from those in the district ministries and DNCC. In this section, we discuss training, the flow of finances, and key challenges to effective financial management of the programme.

Training

MCDP stakeholders at the central level explained that both the DNCCs and WNCCs have received financial management training; no one, however, provided descriptions of when these trainings occurred, how long they lasted, and what topics were covered. Central-level programme stakeholders emphasised that the capacity of officials at the DNCC and various line ministries continues to be low in financial management: 'the absorption capacity at district level is low*.… it is the issue of human resource at the distric*t level*'*. One respondent at CARE explained that they have been attempting to provide guidance to the districts on proper reporting procedures, cognizant of the need for regular training opportunities for district-level stakeholders on financial management processes. Currently this 'training' seems tailored to the needs of those responsible for financial management in the ministry and DNCC offices but occurs informally.

Flow of finance

> 'The delayed funding also has been cited, if you read the report, the annual review that *we did with DFID, am sure that came out as a major factor from the districts to say "we have not been able to implement some of the activities because we haven't received the funding on time." But we are also saying, "well, we haven't fund*ed you because you *haven't submitted the documents on time, you haven't submitted the reports on time"*, even when the documents are submitted, they are not correctly done so there is a lot of back and forth. So it is really the issue of capacity' (CARE office, April 2016).

MCDO implementers explained that funding and planning programme activities are interlinked. Funding is provided quarterly to districts contingent on the district submission of a financial report. A respondent from CARE explained that 'Mbala was funded earlier than Chipata and then there was no funding'.

The flow of programme funding is understood slightly differently amongst respondents. District-level ministries and the DNCC submit a quarterly request for funding to the national level which is tied to corresponding activities from the programme work plan. After this, the NFNC will provide feedback on this request, ensuring that none of the requested activities has already taken place, that activities are appropriately timed, and that targeting is correct. This feedback is given to CARE, who then decide what to approve and fund. Funding is disbursed to the four line ministries, as well as the DNCC contingent, upon the submission of up-to-date financial reports; notably, it is not allocated to the WNCCs. One respondent at the central level explained that funding is not distributed at the ward level because 'there are capacity and accountability issues. It is too high risk'. When funding is disbursed to ministries, one respondent from the Chipata DNCC explained that they are not notified, which makes coordinating activities and programme implementation amongst the various actors challenging.

The issue of 'carrying over' funding for activities which have not yet been completed within a quarter is a significant obstacle to programme implementation. Respondents explained that funding requests can be made only once the money for the first quarter has been spent and accounted for. The DNCC and line ministry focal points may request that funding be carried over, but delays in response time on approvals for carrying over funding further impede interventions. In Mbala, one respondent from the DNCC explained that they asked to carry over funding, but three weeks later had not received a response. The inability to move forwards with funding for interventions unrelated to those activities which have already been funded but not yet implemented disrupts the ability of MCDP implementers to adhere to their work plan and stay on schedule. Even at the national level, the programme's financial processes remain a source of confusion. One member of the NFNC expressed the need for these to be 'cleared nicely so that things are just straightforward (and) people are able to request for money, utilise it, report, and then request for the next amount of money they need'.

Mbala has suffered from erratic funding disbursements as well. These have had a range of effects on the impact chains of interventions. As in Chipata, time-sensitive activities such as season-dependent agriculture plans and calendrical ones such as Breastfeeding Week have been compromised because of funding delays. Delays also have diminished the effectiveness of trainings because of the gap between learning and action. As in Chipata, intersectoral

coordination is more difficult in the face of funding inconsistencies across line ministries. Finally, late disbursements can lead to hasty implementation and can set off a chain reaction involving further delays due to carry-over requests.

Financial reporting

Financial reports are provided quarterly and attached to the activity reports. They are submitted separately by the four line ministries and the DNCC, as each of these entities receives funding separately. In Mbala, however, the DNCC decided to merge the reports from all the line ministries into one consolidated document, which they now submit to CARE. One member of the Mbala DNCC explained that they recently made this decision so that '*CARE couldn't claim that* they had not received one from one particular ministry'. Financial reporting procedures are described as very time-consuming. One member of the NFNC noted that often the time spend on submitting funding requests and financial reports is actually more than the time spent implementing programme activities, recommending the following:

> *'*What we would like to see maybe is biannual requests, sending every six months. Because at the moment even reporting on activities seems to be a huge problem, because you have started this activity (and) it is not yet done and you have to report…. *I think* maybe the project is huge and the time limit is being affected by these procedures we have to follow*'*.

Challenges

Coordination and communication issues are raised by both WNCCs as key reasons behind programme delays and inefficiencies. WNCC members reported that they are not consulted for input into MCDP activity planning in their wards, nor do they have the opportunity to manage programme funding for such activities. Because the WNCC does not operate according to its own work plan, respondents explained that they wait for directions from the DNCC once it is funded, though the planned activities may not be relevant to the population. One member of the WNCC in Chipata observed this:

> *'*We will just be directed in one direction of a plan that has already been done and funded. Meaning that even when IEC sensitisation is not important in your area at that time you still need to do that sensitisation because it was planned by someone in the DNCC*'*.

The lack of understanding of the needs within a district's population indicates the need for better communication between the DNCC and WNCC in developing work plans and efficiently allocating funding. A WNCC in Chipata explained that they received a financial orientation, but that after submitting a ward action plan so as to receive direct funding, they have yet to receive an update or approval to follow through with plans. Similarly, in Mbala, one respondent explained that the WNCC has expressed a desire to have discretion over activities, and that a new work plan being developed will be shared with them. It is clear that mistrust of responsibility and accountability over intervention funding exists at all levels of the programme; this affects programme coordination and communication processes, as well as transparency amongst MCDP stakeholders.

The timeliness of funding disbursements for MCDP activities is essential to the programme's efficacy, yet continues to be perhaps the most pressing challenge in need of addressing. Implementers in both Chipata and Mbala explained that many funding requests are time-sensitive. Therefore, when they are not processed on schedule, implementation is significantly affected and in some cases the feasibility of carrying out the requested interventions is compromised. One member of the Chipata DNCC discussed this challenge:

> 'So you find that when you plan for an activity, it is difficult to implement because of lack of funding which comes a bit late.... *when such funding demise happens…it doesn't come* on time as expected because there are certain activities that are time bound, for example, the commemoration of world breastfeeding week. As Ministry of Health we do that in *August, so if I apply for money and it doesn't come within that period then that activity* will just pass*'*.

Funding flow delays have not only broken the chain of impact in missing periodical activities such as child health week and breastfeeding day, but also by missing deadlines for seasonal activities, such as the need for timely delivery of seeds prior to the rainy season. Delayed funding also causes gaps in programming, which decreases the effectiveness of prior activities. One member of the Mbala DNCC said that 'you have trained them, then you take 100 years to give them the inputs; they can even forget some of the messages and they get demoralised*'*. When interventions occur sporadically because of inconsistent funding, it is difficult for MCDP processes to be institutionalised and thus achieve impact. Instead, implementers at the community level may focus on their non-SUN-funded work. One respondent at the DNCC in Chipata noted that the MCDMCH has received funding only once during the second quarter of 2015, illustrating this problem.

Technical

In this section, we discuss the implementation of priority interventions against the backdrop of the issues raised earlier in the report. It is important to make two observations at the outset. The first is that it was not always possible over the course of research to systematically distinguish between preexisting activities and those which have been supported by the MCDP programme. The nature of the programme is principally to support, extend, and strengthen existing interventions: as discussed earlier, the MCDP introduces a new mode of delivery and builds on existing interventions rather than creating entirely new ones. Informants at all levels were found to be somewhat unclear on what was 'SUN-supported' and what was not. This was especially true farther down the programme chain and also is probably related to the irregularities in funding disbursements. The second observation which should be made is that the reporting offered here does not benefit from programmatic data, which was not systematically collected for two reasons: first, because in the absence of consistent and functional monitoring tools, such data is patchy at best and unreliable at worst. Second, because roll-out is still immature as a result of the irregular funding flow, many of the standard metrics offered by programmatic data were simply unavailable at the time of research.

Cluster 1: IFA, vitamin A, deworming

Activities

In Chipata, respondents from the DNCC, the WNCC, and ward-level implementers agreed that both IFA tablets and vitamin A tablets are distributed regularly. In addition, pregnant women are sensitised to the importance of IFA: according to a community health worker from Nsingo ward, 'We offer counselling on the importance of IFA to the pregnant women including those that say that they have enough blood'. The in-charge from Nthope ward made a similar point, adding that SMAGs are responsible for sensitising women about IFA during community meetings. Many respondents indicated that distribution of iron, folic acid, and vitamin A happens at the antenatal clinic, GMP stations within the wards, or through the SHN initiative. Many respondents mentioned Child Health Week, which happens twice per year around the months of June and December, in conjunction with deworming. Deworming and vitamin A were frequently mentioned together, for example by a school official from Nsingo ward, who stated, 'children are dewormed every second term of the year, clinic staff come to the school and distribute deworming tablets and vitamin A tablets'.

Training

Most of the trainings mentioned in relation to iron, folic acid, vitamin A, and deworming took place during Child Health Week. One SMAG from Nsingo ward noted that these trainings during Child Health Week provide helpful guidance on the age at which children should receive each sort of tablet: 'They tell us the age of children who are eligible to receive a particular type of vitamin A and deworming tablets. Children aged 6 to 11 months get blue vitamin A tablets, those aged one year to 5 years get red vitamin A and deworming tablets'. Responses were somewhat mixed on whether respondents had received training materials to facilitate activities related to iron, folic acid, vitamin A, and deworming. According to one SMAG from Nsingo ward, 'I have *not received any brochure or kit to help me conduct my activities. I use each child's* under-5 card to know what medicine to give the child'. A few respondents mentioned instructional leaflets and posters associated with Child Health Week, also noting that these materials would be more useful if they were in Nyanja rather than in English.

Challenges

Although one respondent mentioned that district offices occasionally run out of tablets, for the most part it does not appear that inputs are lacking for IFA, vitamin A, and deworming activities in Chipata. The one input-related issue mentioned by the WNCC in Chipata is that it is not always clear where supplies—including IFA tablets—are coming from (whether the MOH or SUN). Instead, SMAGs and community health workers mentioned very specific challenges, such as women's' resistance to taking IFA tablets because the tablets make them nauseated or give them headaches, or just simply the tablets smell bad. A SMAG from Nsingo ward noted that some pregnant women resist taking IFA tablets because they think they have already taken enough.

The nutrition champion from Nsingo ward indicated that some mothers do not understand when children should receive vitamin A:

> *'Since it has to be administered every six months, you find that some mothers don't* understand if there is c*hild is not due for vitamin A and want to receive. Or if the child's* age is not yet due to be receiving vitamin A, we explain this to them that they have to wait a couple more months in order for their child to receive the supplement and that in the *meantime they get their vitamin A from their breast milk but some don't seem to* understand this, but others do*'*.

Last, one school official mentioned that it is sometimes difficult to distribute multiple tablets at the same time to children at school, particularly when some of them (such as the medication for bilharzia) cause drowsiness.

Positive changes due to MCDP

Most respondents from Chipata, including members of the WNCC, felt that SUN had brought minimal or no changes to activities related to IFA, vitamin A, and deworming activities. According to a WNCC member, *'*There has been no change in either administration nor in the delivery since when SUN started*'*. That said, at the ward level, some respondents maintained that SUN has routinised vitamin A and deworming activities. According to the in-charge in Nsingo ward,

> *'*The approach was changed when SUN in. They told us to capture the moment they have turned six months and 12 months. When they are six months, we give vitamin A. When 12 months, we give deworming. Those who are due they receive at the age that they are supposed to be given*'*.

Several other positive changes were mentioned at the ward level, although it is unclear whether these changes occurred as a direct result of SUN. In Nthope ward, one health worker remarked that as a result of sensitisation, community members are now bringing their children in for deworming and women are visiting the under-5 clinics more regularly. A SMAG from Nsingo ward perceived a reduction in cases of anaemia: *'*From the time we started administering IFA tablets to children and pregnant women here at the clinic, we have not recorded any cases of anaemia*'*. With regard to deworming, the in-charge from Nsingo ward suggested that deworming activities are no longer limited to Child Health Week: *'*a long time it was a biannual thing deworming children but now we deworm when they are due. At 12 months we deworm. There is nothing like we have to wait until the minister declares this is child week that when you deworm*'*.

Cluster 2: Breastfeeding and complementary feeding

Activities

In Chipata, the WNCC mentioned a mothers' group focused exclusively on sensitisation and training about appropriate breastfeeding practices, separately from the SMAG. The exclusive focus on breastfeeding is 'working well' according to the WNCC member interviewed, and mothers participating in the group received a training from Katcele. In Nsingo ward, the in-charge mentioned drama performances to educate pregnant women on the importance of breastfeeding and the importance of antenatal visits. The SMAG nutrition champion in Nsingo mentioned weekly meetings with pregnant women *'*on feeding and the importance of taking care of themselves, the baby and their health*'*. She also mentioned monthly breastfeeding meetings during growth monitoring activities, during which they use drama, songs, sketches, and poetry to

educate participants about breastfeeding. Also in Nsingo ward, the in-charge mentioned plans for a garden and cooking demonstrations to promote healthy complementary feeding practices, but these activities have not yet begun.

In Mbala, the DNCC reported that cooking demonstrations had been presented in several wards as part of Child Health Week. The activity began with drama sensitisation followed by a cooking demonstration one month later, during which participants were divided into two groups and tasked with making a certain recipe and then teaching the other group how they did it the following day. The Mbala DNCC also indicated that counselling on breastfeeding had been done and that four IYCF facilitators were in the midst of training community volunteers on breastfeeding and complementary feeding.

Training

The training received by MCDP implementers in Chipata varied, with some saying they had not yet received any formal IYCF-related trainings and others indicating they had received detailed training on breastfeeding. Exposure to training appears to vary even within a single ward. In Nsingo ward, whilst one SMAG said, *'I have not been trained in IYCF/C-IYCF. I counsel people based on the knowledge that I receive from the in charge and from reading books and pamphlets that the in charge gave me'*, the in charge recounted a detailed training on breastfeeding: *'before the training, I knew a certain way in which the mother should hold the breast when breastfeeding but after the training I discovered that what I knew was wrong. I learnt the correct method in which the mother should hold the breast so that milk comes out in the right way'*. Last, the Chipata WNCC expressed a desire for more training materials, saying, *'We received a number of leaflets but the way we can only orient them rather than properly train'*.

Challenges

The primary challenges associated with breastfeeding and complementary feeding activities in Chipata relate to inputs and supplies. The perceptions of resource needs also seem to differ slightly at the district and ward levels, with some DNCC and WNCC staff reporting to the research team that sufficient resources had been provided for an activity and ward-level implementers expressing a need for additional resources for that same activity. For example, in both Nsingo and Nthope wards, respondents mentioned the lack of food supplies for cooking demonstrations to be a key obstacle in implementing that activity. At the district level, however, the WNCC commented, 'We learnt that we could just ask the mothers to bring locally available foods*'*. Ward-level respondents indicated that asking participants to supply the food for cooking demonstrations is actually not a viable solution. Also, on the subject of cooking demonstrations, the in-charge from Nsingo ward added that they need utensils for the demonstrations which they have yet to receive. Another example of differing perceptions of resource needs at the district and ward levels is bicycles. Although the WNCC in Chipata commented that all SMAGs had been given bicycles to follow up on group breastfeeding and complementary feeding trainings house by house, breastfeeding committee members from Nthope ward indicated that they lacked bicycles to be able to follow up on group breastfeeding and complementary feeding trainings.

Respondents in both Nthope and Nsingo ward reported needing training materials for IYCF activities, with one health committee member saying *'I have not received any materials to*

conduct IYCF and C-IYCF activities.*'* One SMAG from Nthope ward agreed, maintaining that IYCF trainings should include pictures: *'*they should be using pictures when teaching. These are pictures of different foods for children and cooking methods*'*. One non-resource-related challenge reported by a SMAG in Nthope ward was that men often do not accompany their wives to antenatal visits, thus limiting men's exposure to MCDP training on breastfeeding and complementary feeding.

Positive Changes Due to MCDP

In Chipata, one growth promoter indicated that SUN has enabled her to travel to women's homes to teach them about breastfeeding, whereas before they were able to teach only women who came to the under-5 clinics. An in-charge from Nthope ward said the MCDP has brought formal trainings related to maternal and child nutrition which were previously lacking: *'*there is a difference because before we never used to have these trainings, like the training the one which I was speaking of, the nutrition for mothers and babies, we never used to have that. So we were doing it, but now we are doing something that is even documented*'*. Respondents from both Nsingo and Nthope wards commented that mothers pay close attention during trainings and frequently ask questions. A community health worker from Nsingo said, *'*The mothers pay attention and ask questions and freely share their experiences. Some of them go a step further to bring suggestions and others bring their children to me to see the appearance of the baby and we freely discuss on how they should feed the baby to improve the condition*'*. Similarly, in Nthope ward, a community health worker reported that although communities were previously resistant to the concept of exclusive breastfeeding for children under six months of age, *'*people are now more receptive to it. They listen to us when we carry this message*'*.

In Mbala, respondents reported a shift in dialogue about child feeding as a result of the MCDP. According to the WNCC, *'*IYCF was there, but the issue of first 1000 *days wasn't there. It* changed the way we talk to mothers (not only about the brain but also about nutrition). Also, before we were not taking MUAC tape*'*. The Mbala WNCC remarked on the importance of cooking demonstrations, which were rarely done before the arrival of the MCDP in Mbala: *'Cooking demos are the best because mothers don't know how to cook. Before SUN it was rarely* done (only mothers of malnourished children which we bring to the centre). Mothers will say *'No, we didn't know that*!*"'*

Cluster 3: Growth monitoring and IMAM

Activities

Respondents in Chipata and Mbala mentioned two main activities related to growth monitoring and IMAM, sensitisation and growth monitoring sessions. In Mbala, the DNCC reported that sensitisation on growth monitoring is 'continuous' and takes place prior to each growth monitoring event, usually led by a volunteer or a community health worker. According to the WNCC in Chipata, growth monitoring takes place monthly at stations operated by the under-5 clinics:

> *'*To do [growth monitoring], what happens is every baby born, the mother is given a station where the under-5 clinics are held, so they are given a date on which to bring the

> child to be given vaccines and so on. So they are always given a schedule for when the children are monitored on their growth and given the vaccines. So every child is being monitored every month in all the zones*'*.

In Nsingo ward, a community health worker mentioned that as many as 80 or more women attend each growth monitoring session in large villages, with closer to 40 women attending each session in smaller villages. Growth monitoring sessions typically involve songs, dance, and poetry, as well as counselling on breastfeeding and complementary feeding.

Training

In Nthope ward, Chipata, respondents mentioned plans to train 30 growth promoters per year but indicated that they had not yet begun the trainings. In Mbala, the DNCC mentioned plans to train 180 volunteers on growth monitoring in a comprehensive five-day training which includes not just measuring height and weight but also *'how to communicate…interpret the weight, counsel* the woman, make the follow-up visit, talk about certain diseases*'*. According to the DNCC, however, funds are not sufficient to train 180 volunteers: *'*The 180 number was our objective, we wanted to achieve it but then when it came to implement we realised that the money that we had was not adequate to cover all of them*'*.

In terms of the training health workers and volunteers themselves receive in growth monitoring and IMAM, a SMAG from Nsingo indicated they have not received any formal training, and mistakes are made as a result:

> *'*I have not received training on growth monitoring. I just receive instructions from the clinic staff on what to do during growth monitoring. I feel this way of learning is not sufficient. We do not get to know in depth what we are supposed to do. As a result, we make mistakes when recording on the card and tally sheets. We each record the weights on the card differently. Thus I deem it very important that we should have a more serious training*'*.

Challenges

The primary challenges related to growth monitoring and IMAM in Chipata are related to supplies (height boards, scales, and MUAC tape). Some respondents reported having insufficient numbers of height boards, scales, or MUAC tape and others reported having none at all. A DNCC member from Chipata noted, *'*we only received two scales for almost eight zones, so we are still sharing the scales and like the measuring board it*'*s only one for adults that we received, so they are not enough as of yet*'*. The Chipata DNCC added, *'most of the scales don't last, you* find that after some time it stops working*'* and mentioned that transportation is another inhibiting factor for growth-monitoring activities.

In addition to the problems with growth-monitoring equipment, one health worker from Nthope ward mentioned they do not have anything for mothers of malnourished children:

> *'even if we find a baby who is malnourished we don't have anyt*hing to help the mother other than the zinc, that is all. If they need to go to the hospital we just refer to the

hospital. But thereafter there is nothing it's just the counselling on the feeding of the baby, we don't have anything to give them'.

Two other challenges related to height boards were mentioned in Chipata and Mbala. In Mbala, the DNCC noted that heights are not routinely taken: 'we only measure height when the kids get identified as low weight for age.... *We don't do measure height during regular* child growth monitoring*'*. In Chipata, the in-charge noted apprehension about measuring children because there is a misconception that they are being measured for their coffins: 'Though the height board is a bit challenging because people here know that when you are measuring babies in this way, it is like you are planning to make a coffin for them*'*. Finally, a community health worker in Nthope ward mentioned that visual aids would be helpful to educate communities about malnutrition: 'The other challenge is that we lack posters to show people when we are teaching in the communities. It would be nice for instance if people are able to see pictures showing that a child who is malnourished*'*.

Positive changes due to MCDP

Respondents attributed to the arrival of the MCDP a number of positive changes related to growth monitoring and nutrition, commenting specifically on the greater emphasis on stunting and better understanding of malnutrition and the importance of growth monitoring. To this end the WNCC in Chipata commented, *'We've been emphas*ising stunting to make women understand stunting. This has come out very strongly during the SUN program. The women I think have gotten it very clear. The emphasis has been so much after the SUN program*'*. A SMAG from Nsingo ward noted better understanding of the cause of stunting, 'In past years, I did not know that food deficiency can lead to stunting. I thought stunting was only as a result of genotype*'*. In addition to better understanding, some respondents believe the incidence of malnutrition has decreased with the MCDP: a SMAG from Nsingo ward stated, 'Since the SUN started, the number of children with malnutrition has reduced because of their teaching*'*. The in-charge from Nsingo ward remarked that SUN has increased focus on children under 2 as opposed to the traditional focus on children under 5: 'So one thing that I have seen as part of change is that traditionally the health facility focused on the under-5 group but now with the 1000 days the focus is on the under-2 group*'*. Other respondents agreed, adding that more women are visiting the under-5 clinic with their children now for growth monitoring.

Cluster 4: Availability of nutritious foods; dietary diversity for pregnant and lactating women

Because the objective of the Ministry of Agriculture (MOA) is to ensure food security at the household level, this priority intervention sits firmly within their primary mandate. The MCDP activities support the routine activities by strengthening the effectiveness of their mandate: 'it empowers us to act', said a district-level staff member in Mbala. The ministry already focuses on production and processing with the goal of availing foods to various communities, and in the production of fortified crops, especially orange maize, orange-fleshed sweet potatoes, beans; fruits such as pawpaw and oranges, and some local vegetables, all of which are said to be highly nutritious, and most important, locally available.

Dietary diversity sensitisation for pregnant and lactating women

A number of SUN activities pertaining to this priority intervention have been completed in Chipata and Mbala districts, from the district level and cascading to the lower levels, but some planned activities remain to be carried out and completed at the various implementation levels.

Amongst the activities completed are various sensitisations of groups such as the lead farmers and the women's groups on the importance of dietary diversity. Sensitisation activities are easily integrated into the routine activities of the MOA because of their role in determining dietary diversity in rural Zambia. For example, district staff in Chipata incorporate nutrition-sensitive messages of the MCDP into one of their main programs, the Farmer Input Support Programme (FISP), saying, 'as we sensitise the farmers under the FISP, on the 1000 MCDP, we look into diets for children, pregnant women, lactating mothers, as well as complementary feeding and sensitisation'.

The women's groups targeted for these sensitisations generally have a good knowledge of what dietary diversity means and the benefits which can be derived by pregnant women and lactating mothers consuming diverse diets. Groups such as the Luangeni and Mshawa women's group and other key informants too had a good understanding of the importance of this priority intervention, as most were able to state the three food groups which are required in order for a child to grow healthily: body-building foods, energy-giving foods, and protective foods. In each of these food groups, several examples of food were given. Amongst the benefits which respondents believe to accrue to pregnant women consuming diverse diets are the following:

> *'*When they follow diverse diets, pregnant women stay healthy and strong during delivery. The baby is born with a very good weight and this is a sign that the mother was eating well*'*.
>
> *'*Diverse diets are important in the health of my community. Diverse diets enable both mothers and children and other members of the community to grow well. When people have diverse diets, they rarely fall sick*'*.
>
> *'*The importance of diverse diets for a pregnant woman is that blood is not an issue for her, she always has adequate blood and she carries a strong baby in her womb. Even *during delivery she remains energetic, she doesn't become weak easily'*.
>
> *'*When a woman is expecting or pregnant, she should eat three meals in a day plus a snack. The other thing is that she needs to rest after eating. A woman is also supposed to eat three groups of food*'*.
>
> *'*The foods that make a balanced diet include energy-giving foods, body-building foods, and protective foods. For body-building foods we can talk of milk, eggs. For example, we can talk of eggs, groundnut, various vegetables, and various fruits. So it means any mother who feeds on these will deliver a healthier baby*'*.

It is unclear whether this knowledge has been generated during the roll-out of the MCDP, but several of the women cited antenatal clinics as their main source of nutrition and health information.

Another way that sensitisation activities have been done by collaborating district offices from the various implementing ministries in Mbala and Chipata is through cooking demonstrations. At cooking demonstrations, various food dishes are prepared, combining foods from all three food groups to illustrate to local communities how diets can best be diversified. Components on preservation and processing of foods are included so as to preserve the nutritional value of the food when it is out of season. It has been noted that most of the foods used in these demonstrations are grown locally by members of the communities themselves and hence are generally readily available in season. Various groups of women, as well as lead farmers, have been amongst the main targets of the cooking demonstrations in both districts. The cooking of bio-fortified food crops also is reported in order that the farmers learn methods of retaining the nutrients in those types of food. At the time of data collection, many planned cooking demonstrations in Chipata district had not been done, as it was reported that funding for this activity had not yet been received by the district agriculture office, and so the demonstrations completed by that time were done as part of training during the lead farmers' trainings in certain extension camps, as well in the trainings of the women's groups. The district office at SWCD reported similarly that they had not been able to carry out any activities on dietary diversity as a standalone department after the restructuring in some government departments, for they too had not yet received any SUN funds at the time of our data collection. In Mbala, however, the district office has conducted good training and several cooking demonstrations where people have brought their own locally available food, discussing how to preserve it and how to cook it. The cooking demonstrations were attended by personnel from the districts and members of WNCC.

It remains unclear how effectively these demonstrations have been implemented in Chipata, where they have been scarce and loosely coordinated. It was noted that only one representative from the MOE was present during a cooking demonstration organised by the MOH, whilst no one from the MOA attended, as they were having a workshop at the time.

Drama groups also have been employed at sensitisation events to reinforce messages on the importance of dietary diversity across the target populations, however, this may not be sustainable in the long run should the challenge of a lack of support or motivation for these groups remain.

Availability of foods; distribution of food inputs

In a bid to improve household food availability, the Chipata district office included in their training programme a component of seed multiplication, a process by which seedlings are provided to lead farmers to plant, grow, harvest, and then share with members of the broader community. They also have done demonstrations of this process so that others too can see how to grow and multiply them and do so in a way which minimises the loss of nutrients at the time of harvest and after. This was done because the seedlings were said to be inadequate for distribution to all the targeted households. The district office also noted that because productivity is very low, another technique they are teaching farmers to practice is agricultural conservation so that they can improve on their productivity: *'We are incorporating this even into the First 1000 MCDP so that whatever they have they will at least produce more'.*

Trainings on diverse diets in Chipata, however, were sometimes too superficial and not technical enough. One lead farmer at Mnukwa RHC in Nthope ward lamented the lack of depth of the

training received in which the knowledge on all these processes was being imparted saying, 'to be honest we had *the training on crop production but it was just an orientation, we didn't learn* in detail. We never learnt any planting methods for these crops, there was nothing like that. It was just orientation so that we can have something to teach the community'. Another farmer in Nsingo ward said, 'we were trained but no programme was given. Right now we are waiting to have a programme for fish ponds. The way it is, is that there is no programme that was set for us to follow, they were just teaching'. Yet another added that 'it is difficult to find a starting point. Because those people just came and taught us, but for us to start, that is what is difficult'. One lead farmer of the Mshawa group lamented that 'most of the things that we were taught require money. For instance cement, money to buy fish and construct a fish pond. All these things require money. Even if you sat together where are you going to get the money to do these things. In short, we were taught in theory but we did not do practicals.'

Although Chipata conducted several trainings, the funds were depleted before they could deliver and distribute agricultural inputs to their target groups. In Mbala, however, the district office concentrated on relatively fewer trainings but seemed to be focused more on a community model of agriculture with in-depth trainings during which community members were taught how to construct fish ponds and chicken houses. Afterwards, agricultural inputs have been distributed in a systematic way in which members of the community self-select into interest groups which are defined by the type of input individuals would like to receive. For instance, they have the livestock and vegetable interest groups in which individuals with similar interest in a particular input (for example, goats, pigs, or bio-fortified crops) can regroup and prepare to be eligible for receiving the respective agricultural inputs. For the livestock interest groups, for example, the district staff conducted a selection process as guided by predetermined criteria. According to them, a critical criterion for prospective recipients was having the required structures erected to shelter the livestock, and having attended the trainings, before they could be awarded the inputs.

Cluster 5: WASH

WASH presents considerable differences in intensity between Chipata and Mbala because Mbala is one of the pilot districts for the MOE and UNICEF CLTS intervention, and much of the WASH focus in Mbala is supporting and strengthening the scale-up of the CLTS intervention (support incentives for more CLTS champions and for supporting ODF celebrations), and WASH supports the MOE in training for SLTS. Thanks to the CLTS efforts, many chiefdoms in Mbala have already been declared open-defecation-free and sensitisation efforts are intense. This is not the case in Chipata, where efforts are still at the beginning (*'*it is quite challenging to maintain hygiene with children who have never seen a toilet before*'*, according to a Chipata district head teacher). In addition, because Mbala is supported by the DHIS2 mobile community reporting system, the support for M&E and level of information is dramatically different in the two districts.

CLTS activities' target is broader than the traditional SUN target of pregnant and lactating, just because of the significant externalities. *'*One neighbour open defecating will affect the entire village, including those pregnant and lactating women*'*, said the MLG representative in Mbala. Despite this breadth and the WASH involvement in all spheres of The First 1000 Days, implementers felt it was easy to include WASH messages into their activities.

Both in Mbala and in Chipata, there is a general understanding of the importance of WASH and its role in the first 1000 days in both civil servants and community workers ('one cannot talk about good nutrition without talking about water and sanitation.... *if one eats a balanced diet* but the water points and environment are dirty, the person will not be healthy', said our key informant at a school in Chipata district) and the message about washing hands often is integrated into First 1000 Days sensitisation meetings ('We can look at nutrition just on its own, but nutrition is also important in relation with the other diseases, for example, diarrhoea. When we talk about nutrition aspects, we integrate with other things', said an EHT in Chipata district) and discussed by a Chipata CHV: 'We teach people to construct toilets and not use open defecation. We encourage them to wash hands after using the toilet, wash all the foods they are about to eat in clean water, and to boil their drinking water'.

In Chipata at the time of the visit, activities on WASH were focused on granular chlorination of wells and reorientation of previously trained pump menders. Chlorination of wells is done mostly by the EHT and pump menders, and granular chlorine is kept at the clinic, but at the time of the interview, granular chlorine was almost finished and testing kits and spare parts had not been received at all, which limited the effectiveness of the training and of the intervention. At the household level, liquid chlorine also had not been distributed, and sensitisation at the household level from community workers was therefore encouraging the boiling of water. Community workers and nutrition volunteers all reported teaching about the importance of toilets, clean surroundings, and boiling water, as well as the importance of having a rubbish pit. At the school level, triggering of schools was not yet done as part of SUN activities in Chipata, although some isolated wards have been exposed, thanks to the activities of independent NGOs , and some wards had engaged drama groups to sensitise students and the community on WASH issues and had reported having active student SHN committees. District and ward staff highlighted anecdotes of children sensitised at school bringing about behaviour change in the household: 'I witnessed a child at a home yesterday about four-years-old boy advising the mother *"*make sure you wash your hands before you touch this*"*' (EHT, Chipata district)

In Mbala, many activities in the plan are 'topping up' what has been done by the UNICEF CLTS project, helping to fund ODF celebrations and supporting CLTS champions' incentives. UNICEF SLTS-triggering tools were reported to be implemented and the SUN fund was providing human resources for training in the SLTS component. The DHIS2 system was providing almost real-time data on the CLTS situation and allowing MLG to plan effectively and position resources where most needed. In an innovative example of coordination, the Mbala MLG activities in water quality and boreholes rehabbing were planned with the agriculture-based activities to guarantee that water points are up and working in the areas where production gardens happen. MLG Mbala also systematically mapped the boreholes and their support before deciding which boreholes to prioritise for repair. WASH involves a substantial coordination between MLG, MOH, and MOE, but in Chipata it was too early to assess the success of this coordination: at this point it was limited to logistical coordination between EHT and pump menders.

Challenges in coordination concern the coordination with smaller NGOs: *'*There are other NGOs doing the same things as the SUN program but they are not consulting other groups. They are maybe drilling boreholes where the number of households is very small. They will go drill without consultation about where that borehole should be drilled. We are still having those gaps*'* (WNCC focus group, Chipata); these can be mitigated by a stronger WNCC.

Shallow wells remain a problem in the Chipata and Mbala districts. There was a general feeling that more was needed than just chlorination of shallow wells, potentially construction of better wells or new boreholes (*'MLG says it is not mandated to drill new boreholes, just to rehab, but we have areas that are critically hit by the situation of water points. The water people are drinking is not safe because they are shallow wells where they just use ropes to get water. So some areas are hit by lack of sources to get safe water.… Even the shallow wells*, although they are be*ing treated, the way people draw and handle the water…it needs more'*; 'The MLG said it is not mandated to drill new boreholes, but just to rehabilitate. But some areas are hit by poor water sanitation*'*). In Mbala, the latest Mpika plan includes construction of a borehole to address this challenge.

Cluster 6: Nutrition messaging

Nutrition messaging is the component of the 1000 MCDP which aims to generate and impart nutrition knowledge and health information to local communities. As one nutrition champion in Nsingo affirmed, 'knowledge is power', and this priority intervention is essential in that it lays the foundation for community uptake of the health and nutrition services offered by the programme.

Nutrition messaging is overseen and guided by a communication and advocacy strategy, and the implementation plan is drawn up at the national level and provided to the implementing districts. Various entities manage the development of a nutrition messaging package that depends on the specialisation of the entity in relation to the messages being developed. For instance, messages to do with Maternal and Infant and Young Child Feeding, Complementary Feeding and Growth Monitoring Promotion fall under the auspices of the NFNC in conjunction with the MOH, whilst IMAM falls solely under MOH, and those on WASH under the MLG. Equally, the development of messages carrying nutrition-sensitive agricultural activities and processes is overseen by the MOA. Hence, the communication activities executed by district officers in their communities all essentially emanate from the national level. This collaborating unit also is responsible for producing the various specialised IEC materials to be used in trainings conducted under the MCDP.

Although a substantial amount of training, orientation meetings, and community sensitisations has been carried out in the Chipata and Mbala districts, the roll-out of nutrition-sensitive messaging has been mixed in its effectiveness at imparting knowledge and nutrition-related information, and by extension, on producing behaviour change. Many of the trainings conducted and some meetings attended were reported to have not employed any IEC material carrying nutrition-sensitive messages. Attendants cited the use of plain flipcharts which were handwritten by the facilitator as the sessions progressed (the writing was in certain instances illegible). We can attest to the underemployment of IEC material, as was observed in one of the livestock trainings for lead farmers and women's groups which we attended in Kanyanja Camp in Chipata district. Although one poster on the intervention areas of the MCDP hung on the wall of the training venue, the district officer facilitating the training did not make any reference to it during the proceedings. Nor was any IEC material distributed at the training. The only materials given to participants were a notebook and pen to jot down notes during the training. This situation is not unique to the training at Kanyanja camp, a SMAG representative at Mnukwa rural health centre in Nthope noted: 'I have not received any materials to use when teaching others. The

sanitation people only gave me a pen and a notebook to use when writing reports so that we write reports and submit to them at the sub centre in Chipalamba'. In other cases, the IEC training materials arrived after the trainings had already taken place.

In addition, the central development of most of the nutrition messaging in Lusaka has meant that IEC tools carrying nutrition-sensitive messages have been standardised across all regions implementing the SUN programme without having to adopt relevant media of communication to respective regions. Producing standardised material at a national level to be used at district and ward levels risks hampering the full comprehension of key nutrition messages, as well as the effects of the message on the part of the local people if the messages are not tailored to their local context. For instance, as several respondents reported and also as the research team observed, the IEC materials developed are in the English language and have not been translated into the local languages of the regions where the SUN programme is being implemented. It was also observed that materials produced were text-heavy and should feature more illustration-based messaging approaches.

Finally, the messaging content must be targeted to certain traditions and customs that perpetuate poor feeding practices in respective regions. For example, in Nthope, we were informed that there was a general belief amongst the women of that community that the 'first milk' (colostrum) must not be fed to a baby and so they would discard it into the ground, and yet this is the breast milk which is most essential to a baby's health. Thus, even as nutrition messaging is produced centrally, it is imperative that these messages are unpacked to ensure that the districts understand them fully so that it contributes positively to how they disseminate that information to their communities.

A district officer at SWCD in Chipata noted that there are currently plans to establish an advocacy and communication committee to look into appropriate communication media and that most of the media organisations are in line to become members of this committee. It is hoped that this committee will ensure that key messages on nutrition trickle down to grassroots levels by way of an appropriate medium of communication and that IEC materials will be designed to be more user-friendly and will carry trigger messages which are responsible for driving positive change amongst traditions, practices, and attitudes responsible for widespread malnutrition and stunting in respective communities.

Discussion and Recommendations for Policy and Programming

The overarching narrative of this report is that while the MCDP has had some success in promoting a new multisectoral intervention delivery paradigm and has supported the strengthening, intensity, and extent of some interventions, the programme has not attained its full potential in Chipata and Mbala. There are a number of highly interrelated reasons for this, and we hope that the findings presented in this report go some way towards illuminating them. In this final section, we summarise the key findings and offer a set of practical recommendations which we believe would help to mitigate some if not all of the challenges identified. We focus these recommendations mainly on the nonintervention areas of this report (coordination, communication, planning, monitoring, reporting, and flow of finances). This is because we

believe that many of the challenges currently facing the roll-out of priority interventions are directly related to these broad and cross-cutting issues. Resolving challenges in these transversal areas, we hope, would help to resolve challenges to the implementation of the interventions themselves.

Cross-cutting issues

In both Chipata and Mbala, we found that higher (district, WNCC) levels of actors had a good conceptual understanding of the implications of the multisectoral paradigm and coordinated approaches to implementation. This understanding diminished, however, further down the programme chain. Furthermore, although some coordination in activity planning and implementation (chiefly in the area of sensitisation) was under way (particularly in Mbala), it was limited by the overall slowness of activity roll-out. In terms of planning and communication, we found challenges particularly along the vertical axis, in particular between the WNCCs and their respective DNCCs: In both districts, WNCC members felt that they did not have particularly good communication with their DNCCs, and that their role had been limited to simply carrying out the orders of the DNCC. We heard calls for greater ownership and autonomy. Finally, moving up a level, we note that line ministry focal points on the DNCC in Chipata reported poor communications with CARE, and repeated requests for funding carry-over went unanswered.

Related recommendations

- Clarify roles and responsibilities for all actors at all levels of the programme.
- Create an information-sharing mechanism so that the various ministries and coordinating bodies can effectively coordinate with one another, communication lines are open, and the programme is transparent.
- Vertical communication, in particular between district (DNCC) and ward (WNCC) levels, is currently perceived as problematic. Consider ways of improving communication: provide funding for more regular meetings and DNCC field trips, ensure that WNCCs receive more regular and complete briefings from the DNCCs.
- Seek ways to foster greater WNCC ownership of the programme activities. WNCCs desire greater autonomy; although this may not be practical, involving WNCCs more actively in activity planning would help to engender empowerment through participation.
- Consider standardising WNCC structures and composition, as well as the possibility of assigning the leadership role to a member of the health cadre.

Respondents we spoke to at the central, district, and ward levels indicated that monitoring processes are not being consistently or systematically carried out. Although a new harmonised monitoring and evaluation plan was recently created, it is not yet operational. Because a unified monitoring tool for the MCDP is lacking, programme implementers extract relevant data from their respective line ministries in an improvisational manner to monitor activities. Using existing ministry registries creates an additional burden for those responsible with the task of reporting. Although the programme targets and would therefore report only on children ages 0–2, ministry registries focus on children ages 0–5, meaning MCDP staff must spend time extracting the 0–2-

year-old children from the registries. Furthermore, confusion over which activities are SUN-funded and which would occur without the MCDP continues to be a challenge for reporting. The lack of clarity in which activities can be attributed to the programme raises reliability problems in what is reported.

Related recommendations

- Formalise regular training opportunities in financial management for anyone responsible for these processes and institute practical exercises for these individuals to build their skills interactively. This will ensure that those responsible for funding requests, which are critical to programme delivery, may develop the skills necessary to keep the programme moving.
- Train on proper monitoring procedures—for data collection, tools, and reporting.
- Submit only consolidated reports from the DNCC, reducing the confusion and inconsistencies inherent in individual line ministry reporting.
- Develop a system which is less complex than extracting information from separate line ministries—it is time-consuming and error-prone.
- Provide on-the-ground mentoring on planning, budgeting, monitoring.
- Include a specific emphasis on documenting and evaluating the new M&E system during the process evaluation to be conducted in October 2016. The longer term recommendation is to adopt a unified and community-based system of data collection with community workers and implementers as data collectors and using mobile platforms to create dashboards and real-time information to both implementers and policymakers. Therefore, we consider it important to integrate as much as possible of the SUN M&E platform into DHIA2 or something similar.

Financial processes and the flow of funds pose perhaps the most significant obstacle to MCDP implementation. There appears to be a fundamental mistrust of accountability over finances between the central, district, and ward levels, causing significant challenges in communication and coordination of financial reporting and approval procedures. Delays in funding disbursements pose substantial problems to implementation of several intervention activities which are time-sensitive, reducing their effectiveness. In addition, when districts need to carry over funding from one quarter to another, the procedures necessary to request this approval cause further delays of interventions. Inconsistent funding also causes programming gaps, leading many to forget earlier activities they may have been a part of, ultimately preventing MCDP processes from being institutionalised by implementers.

Related recommendations

- Consider placing responsibility for carry-over approval decisions in the hands of the DNCC, or at the provincial level, rather than the national level, with the aim of streamlining the process and improving the flow of finances.
- Consider making an administration budget line more accessible to the DNCCs.

- Consider restructuring to create greater separation between the technical assistance and the financial dimensions of the programme, and also assess the possibility of offering more direct funding channels to DNCCs.

Priority intervention implementation

Findings highlighted multiple successes and continued challenges experienced by implementers delivering the programme's priority interventions. In Chipata, IFA, vitamin A, and deworming activities occur regularly and respondents noted that they have sufficient tablets to distribute. Most respondents felt that SUN funds had not significantly added to existing IFA, vitamin A, and deworming activities, though some explained that it has been successful in routinising the activities. MCDP activities in breastfeeding also have systematised a focus on appropriate breastfeeding practices. In Chipata, a separate breastfeeding mothers' group has been established, and sensitisation occurs frequently with pregnant women to encourage and educate women on feeding. Respondents in Mbala reported a shift in dialogue about child feeding as a result of the MCDP. Some respondents we spoke with in Chipata described a training they had received on IYCF, explaining how valuable it was, but others within the same ward revealed they had not yet had an opportunity to attend this training, highlighting perhaps inconsistent targeting efforts for trainings. Resource challenges also were mentioned by ward-level MCDP implementers, who expressed a need for additional resources, particularly for cooking demonstrations and community training activities.

Respondents provided mixed opinions on the ways in which the MCDP has added to growth monitoring activities. Though plans exist to train growth promoters and growth-monitoring volunteers, trainings have not occurred in either district because of funding constraints. In addition, in Chipata, insufficient growth monitoring and IMAM inputs have been provided, causing problems with conducting adequate sensitisation on malnutrition and inhibiting growth-monitoring activities. At the same time, in Chipata implementers emphasised that because of the MCDP, they sensitise a great deal more on stunting, and pregnant and breastfeeding women consequently understand the link between malnutrition and stunting.

A number of SUN activities in dietary diversity have been completed in Chipata and Mbala. Respondents mentioned numerous sensitisation activities which have been integrated into regular ministry functions, as well as cooking demonstrations in Mbala, both of which target farmers and women's groups. Respondents in Chipata reported more challenges in carrying out activities that result from a lack of funding, and the trainings which have been provided were reported as too superficial. In contrast, in Mbala the district office has conducted training and multiple cooking demonstrations, and by conducting fewer and targeted trainings they managed to distribute agricultural inputs systematically.

We also found significant variations between the districts in WASH activities, likely because Mbala already is a pilot district for an MOE- and UNICEF-funded community-led total sanitation intervention. In Chipata, much of the focus in this intervention area surrounded chlorination of wells and orientation of pump menders, and in Mbala activities served to reinforce previous activities done under the UNICEF CLTS project. WASH activities require substantial coordination between multiple ministries and other NGOs conducting relevant activities. Although it is too early to assess the success of ministerial coordination, respondents

indicated that the MCDP has not been in contact with other NGOs to ensure that efforts are appropriately targeted and not duplicated.

Community sensitisation in MCDP priority intervention areas is ongoing, and the roll-out of formalised nutrition messaging still is limited. The IEC materials which respondents did mention had been developed centrally and were in English, and subsequently not as effective as they could be because the target recipients of these materials do not read English. Respondents expressed a clear need for tailored messaging appropriate to the localised traditions and customs which perpetuate poor IYCF practices.

Recommendations related to interventions as rolled out at the time of research

- Minimise incomplete interventions, such as training pump minders without subsequently providing borehole spares.
- In the event of funding constraints, consider a more complete roll-out in a smaller number of wards (as in Mbala), rather than an incomplete roll-out in many wards.
- Clearly define the transition from training to action, and make every effort to minimise the gap between these two
- Clarify procedures for carrying out sensitisation and promote greater standardisation generally. We are not recommending that every ward carries out a given activity in the same exact way, but we are recommending common guidelines and the need for operating procedures. We recommend support in defining delivery mode and all implementation procedures and in developing written procedures for each activity.

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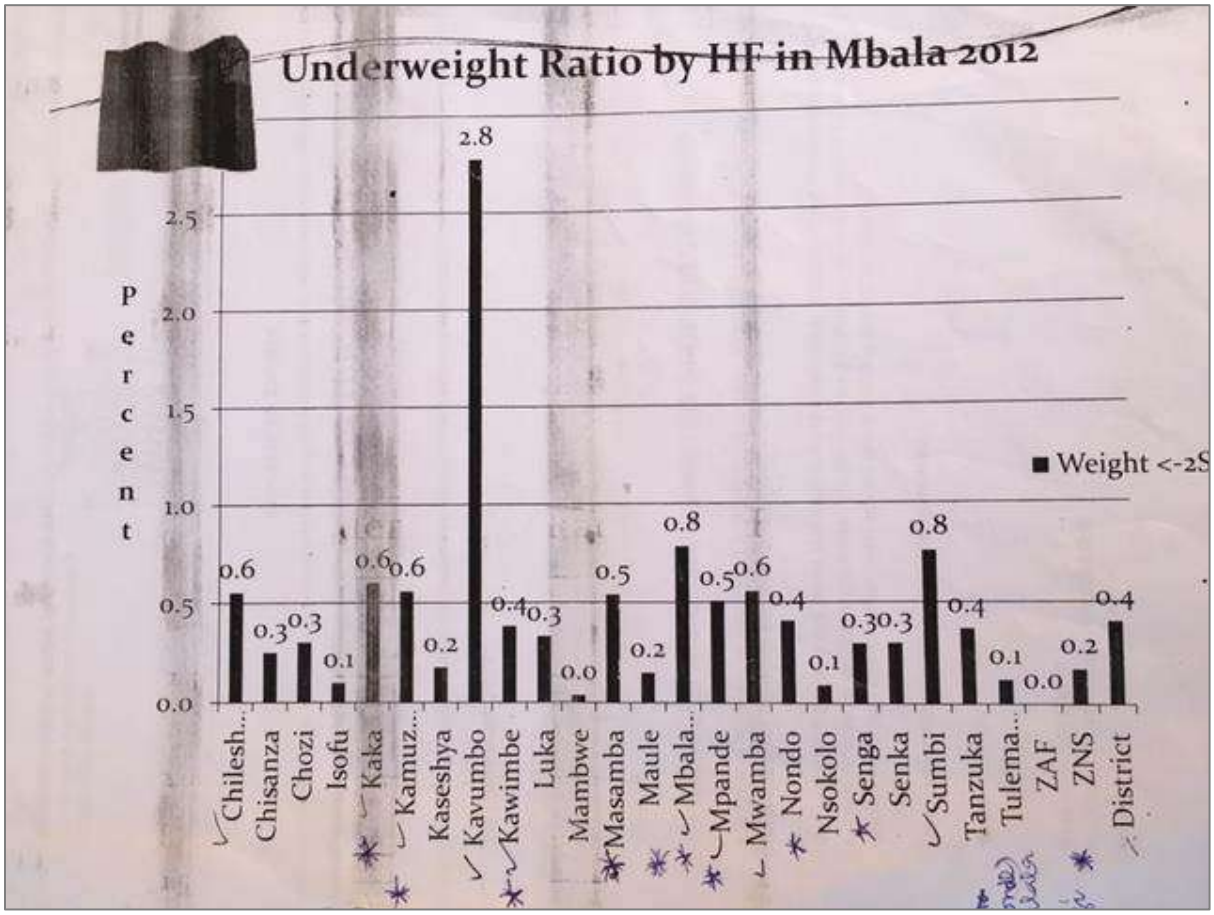
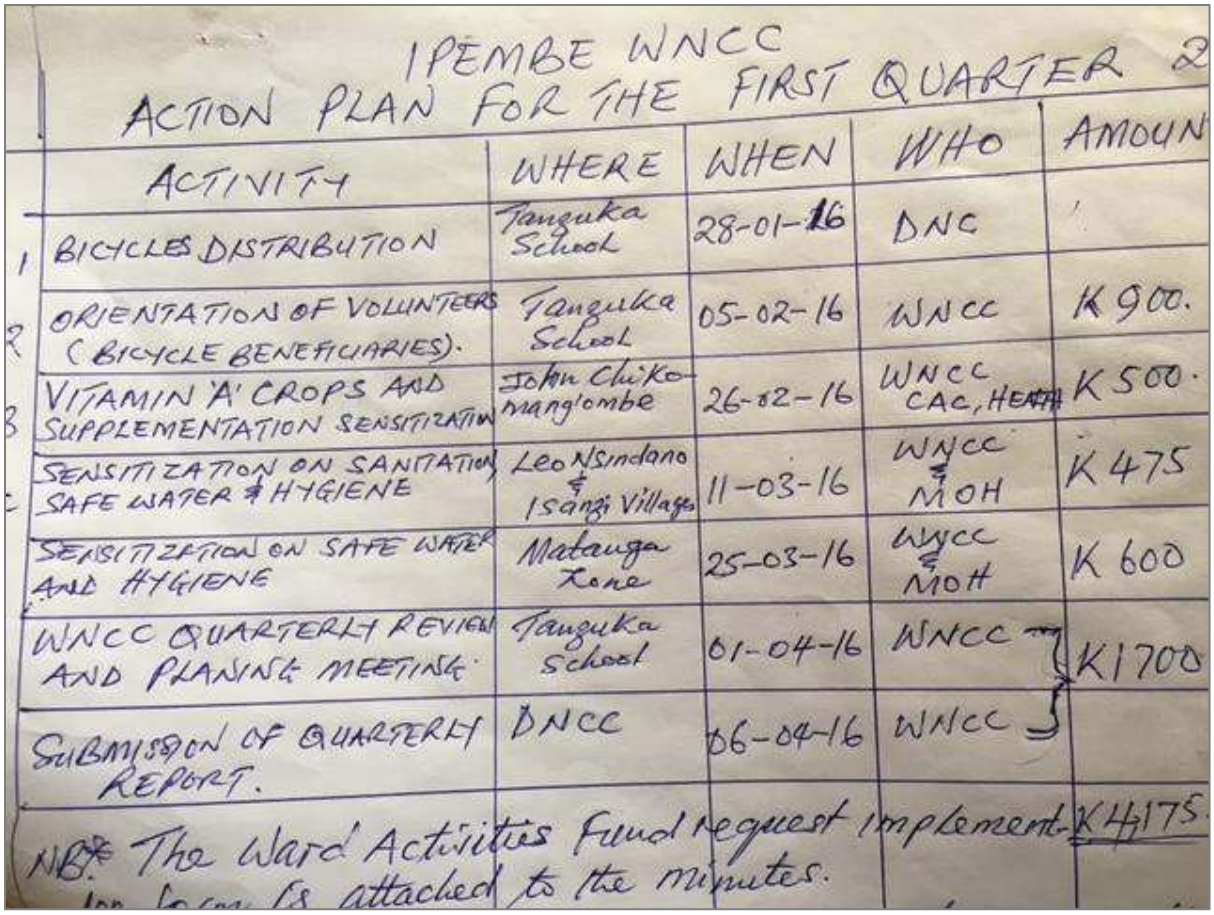
Annex 1: Illustrative Images



In Mbala, selection of wards for most need of intervention was based on this graph, provided to all line ministries by the district health officer. The graph has an unknown source (even according to DHO), does not have confidence intervals, and is based only on wasting rather than on stunting. All districts have lamented that the baseline survey conducted by NFNC ahead of First 1000 Days implementation was not shared with the districts.

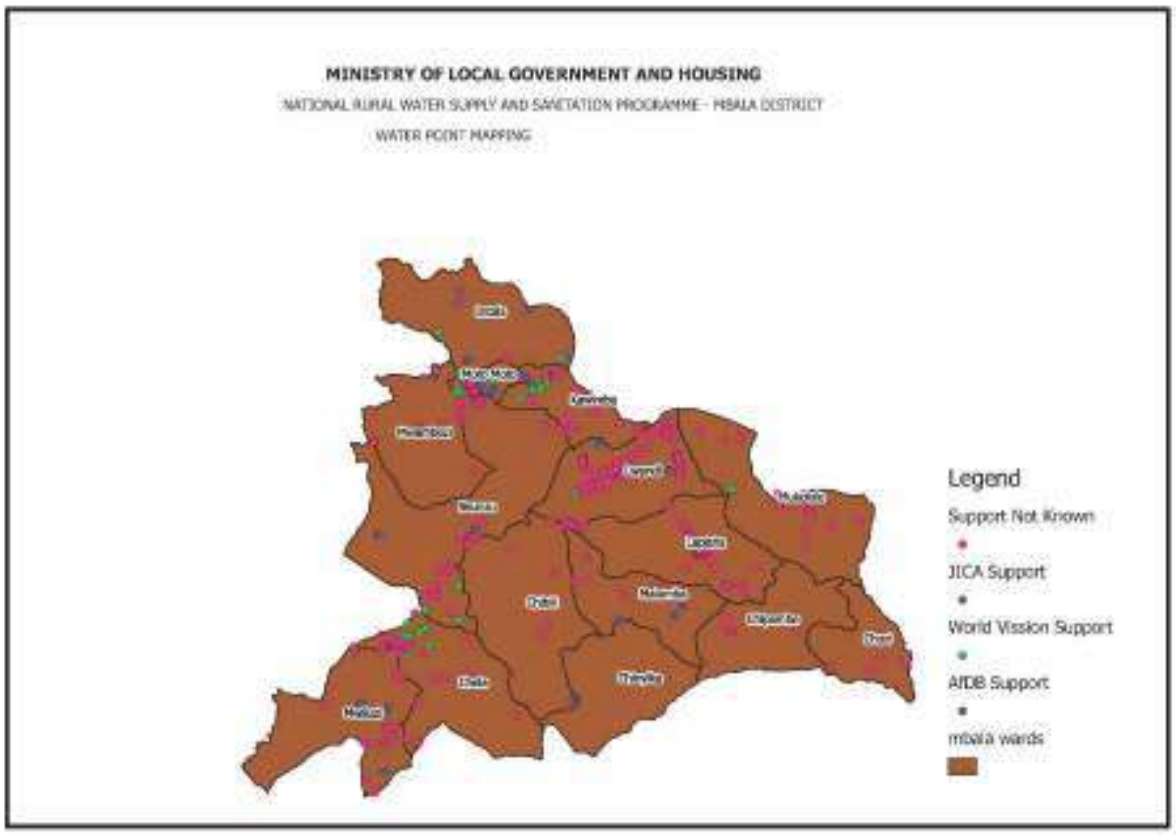


IPEMBE WNCC
ACTION PLAN FOR THE FIRST QUARTER 2

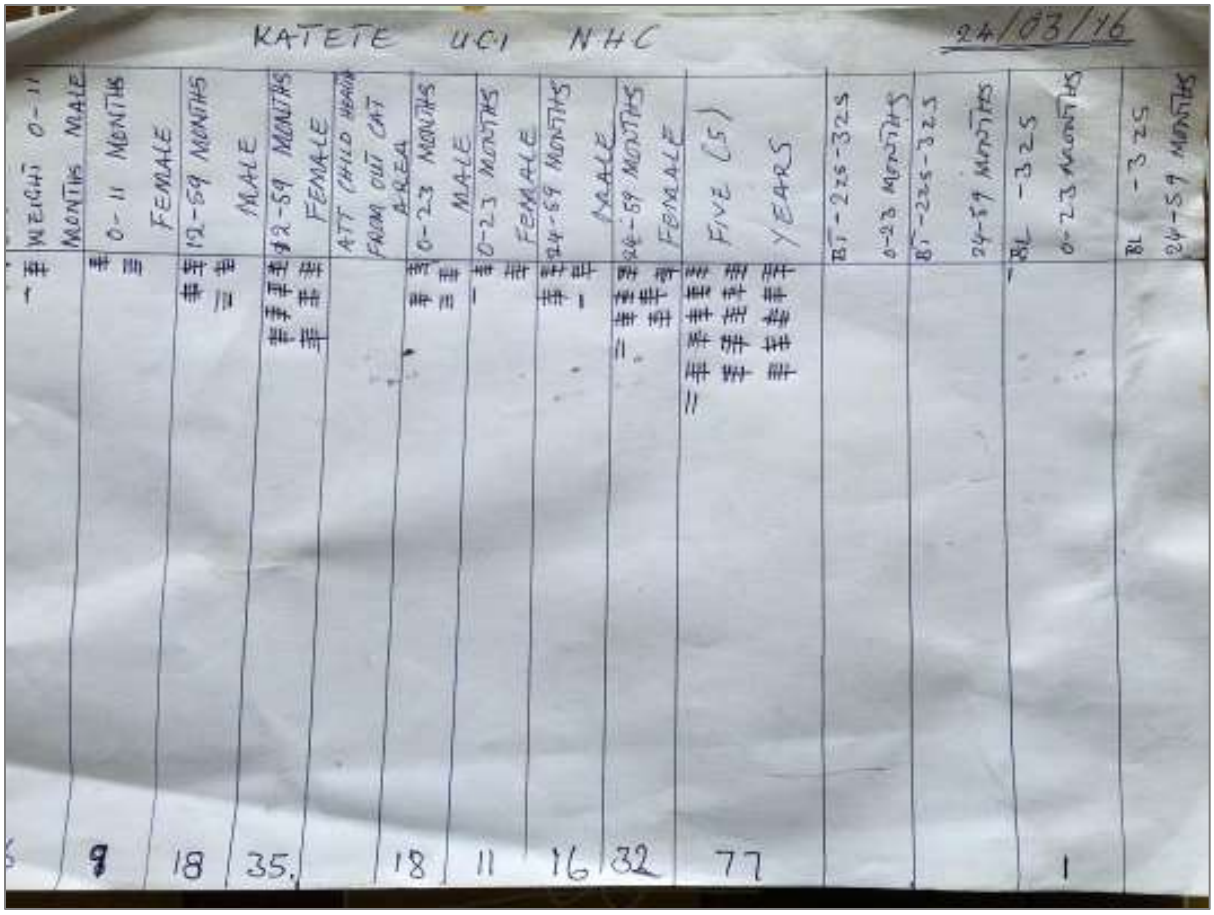
	ACTIVITY	WHERE	WHEN	WHO	AMOUN
1	BICYCLES DISTRIBUTION	Tanguka School	28-01-16	DNC	
2	ORIENTATION OF VOLUNTEERS (BICYCLE BENEFICIARIES).	Tanguka School	05-02-16	WNCC	K 900.
3	VITAMIN 'A' CROPS AND SUPPLEMENTATION SENSITIZATIO	John Chiko Mang'ombe	26-02-16	WNCC CAC, HEATH	K 500.
	SENSITIZATION ON SANITATION SAFE WATER & HYGIENE	Leo Nsindano & Isanzi Village	11-03-16	WNCC & MOH	K 475
	SENSITIZATION ON SAFE WATER AND HYGIENE	Matanga Zone	25-03-16	WNCC & MOH	K 600
	WNCC QUARTERLY REVIEW AND PLANING MEETING	Tanguka School	01-04-16	WNCC	K1700
	SUBMISSION OF QUARTERLY REPORT.	DNCC	06-04-16	WNCC	
	NB* The Ward Activities Fund request / implement				K4175.
		attached to the minutes.			

WARD-level implementation plan in Mbala. Wards will need more formal tools consistent across wards, and activities will need to go under objectives, as in the DNCC plan. The location will need to be justified as well as the delivery mode for sensitisation. Also, the double presence of 'MOH' and 'WNCC' in the chart seems to suggest some inefficiencies: *'*sometimes what happens is we may apply for the funds which are not in the district plan, as a result they will say *we don't have this activity funded in the plan'*, added the WNCC.

Head teacher and WNCC member in Mbala by the community gardens. In this ward, interest groups created vegetable gardens after being given training in vegetable gardening and seedlings from DACO *'*We used to underrate the value of vegetables*'*, she said.

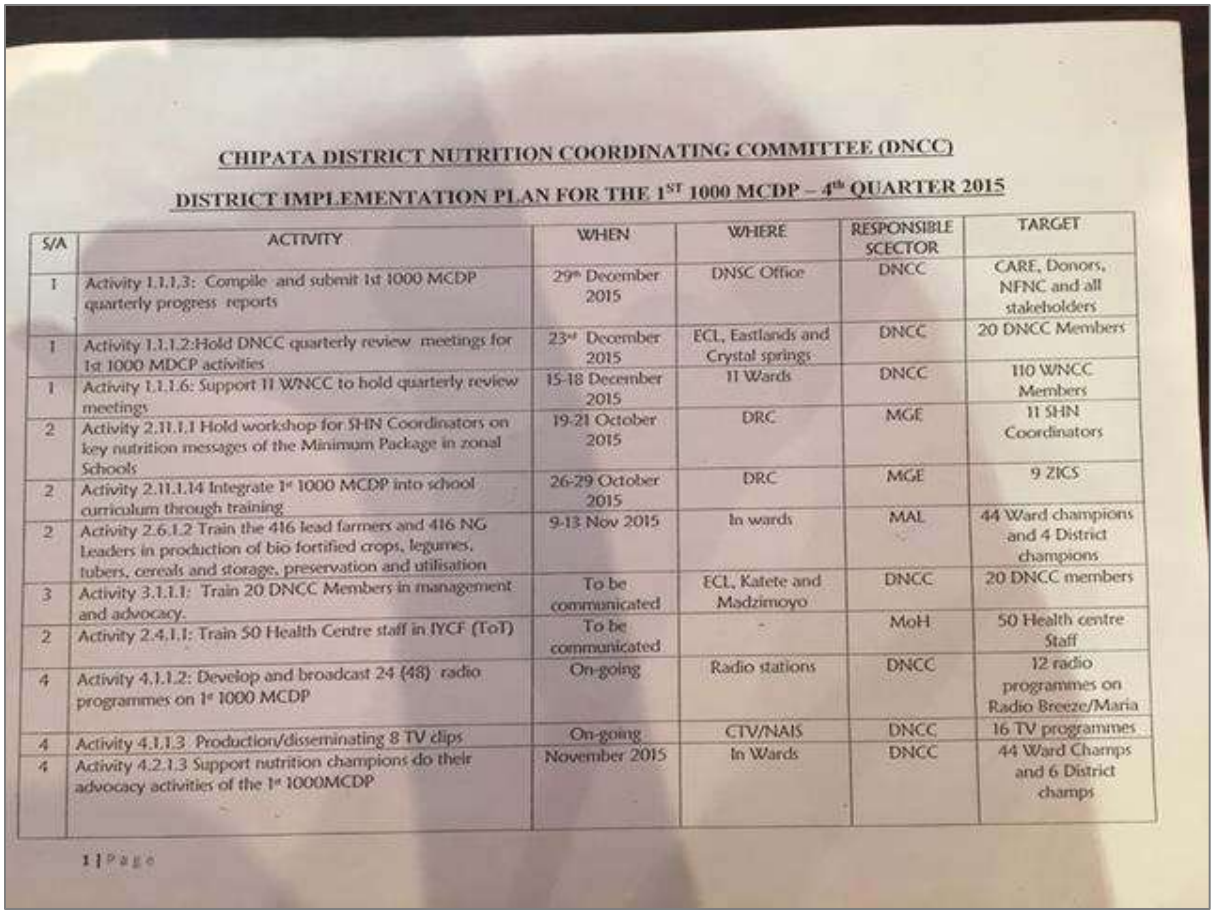


MLG Mbala proceeded in a systematic way to understand which boreholes needed support by mapping all boreholes first, assessing their location and functionality and then prioritising. This was made possible thanks to the UNICEF CLTS project, which provided the infrastructure for good data visualisation tools. The systematic approach of this example should be extended to all wards and activities.



Tally for a typical Community Growth Monitoring event in Chipata district. In this case, data on taking weight of children under 2 years old were recorded on this tally sheet and used for reporting purposes. This is not always the norm.

First 1000 Days material on the notice board of a clinic in Chipata district. The EHT declared that the material was very useful but regretted that it was all in English. He requested that the material be translated into local languages for community workers and mothers to learn.



CHIPATA DISTRICT NUTRITION COORDINATING COMMITTEE (DNCC)

DISTRICT IMPLEMENTATION PLAN FOR THE 1ST 1000 MCDP – 4th QUARTER 2015

S/A	ACTIVITY	WHEN	WHERE	RESPONSIBLE SCECTOR	TARGET
1	Activity 1.1.1.3: Compile and submit 1st 1000 MCDP quarterly progress reports	29th December 2015	DNSC Office	DNCC	CARE, Donors, NFNC and all stakeholders
1	Activity 1.1.1.2:Hold DNCC quarterly review meetings for 1st 1000 MDCP activities	23rd December 2015	ECL, Eastlands and Crystal springs	DNCC	20 DNCC Members
1	Activity 1.1.1.6: Support 11 WNCC to hold quarterly review meetings	15-18 December 2015	11 Wards	DNCC	110 WNCC Members
2	Activity 2.11.1.1 Hold workshop for SHN Coordinators on key nutrition messages of the Minimum Package in zonal Schools	19-21 October 2015	DRC	MGE	11 SHN Coordinators
2	Activity 2.11.1.14 Integrate 1st 1000 MCDP into school curriculum through training	26-29 October 2015	DRC	MGE	9 ZICS
2	Activity 2.6.1.2 Train the 416 lead farmers and 416 NG Leaders in production of bio fortified crops, legumes, tubers, cereals and storage, preservation and utilisation	9-13 Nov 2015	In wards	MAL	44 Ward champions and 4 District champions
3	Activity 3.1.1.1: Train 20 DNCC Members in management and advocacy.	To be communicated	ECL, Katete and Madzimoyo	DNCC	20 DNCC members
2	Activity 2.4.1.1: Train 50 Health Centre staff in IYCF (ToT)	To be communicated	-	MoH	50 Health centre Staff
4	Activity 4.1.1.2: Develop and broadcast 24 (48) radio programmes on 1st 1000 MCDP	On-going	Radio stations	DNCC	12 radio programmes on Radio Breeze/Maria
4	Activity 4.1.1.3 Production/disseminating 8 TV clips	On-going	CTV/NAIS	DNCC	16 TV programmes
4	Activity 4.2.1.3 Support nutrition champions do their advocacy activities of the 1st 1000MCDP	November 2015	In Wards	DNCC	44 Ward Champs and 6 District champs

1 | Page

'This is what we received; it is the DNCC implementation plan; at the ward level we have to produce something like that as well, trying to fit in what has already been planned. The DNCC gives us this, but too late.... *Like for this year 2016* January to March, we still don't have' [April 2016].

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