

Improving Service Readiness and Provider Capacity

Summary Findings from the Endline Assessment of the MCSP Madagascar Program

August 2019

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Background

Since 2014, USAID's flagship Maternal and Child Survival Program (MCSP) has supported the Ministry of Health (MOH) in Madagascar to accelerate the reduction of maternal and newborn mortality. MCSP's interventions aligned with Madagascar's Roadmap for Accelerating the Reduction in Maternal and Newborn Mortality, especially Strategy 3: "Providing essential integrated and quality services around pregnancy and childbirth, focusing on teenagers and youth health." MCSP assisted the MOH to improve facility readiness to provide maternal and newborn health (MNH) services and strengthen clinical practices in 822 facilities across 16 regions (see Key Facts box). The primary approaches to achieve these objectives included in-service and pre-service training, supportive supervision and mentoring for health facility clinical staff, clinical governance and quality improvement (CG/QI) activities, including the creation/support of QI committees and institutionalizing facility-based quality dashboards of high-impact interventions, and supplying basic MNH and family planning (FP) commodities including implants, intrauterine devices (IUDs), blood pressure cuffs, stethoscopes, fetoscopes and newborn resuscitation kits¹. This brief provides a summary of findings from an endline health facility (HF) and provider knowledge assessment along with qualitative data obtained from stakeholders regarding their perspectives on MCSP interventions. These data complement the service delivery results monitored via facility quality dashboards, the results of which can be found in the project-produced *Improving Quality of Maternal and Newborn Care and Postpartum Family Planning Services* technical brief².

Box 1: MCSP Madagascar Key Facts

- Project start date: July 2014
- Project end date: March 2019
- Geographic focus: 16 regions (Alaotra Mangoro, Amoron'i Mania, Analamanga, Analanjirifo, Atsimo Andrefana, Atsinanana, Boeny, Diana, Haute Matsiatra, Ihorombre, Melaky, Menabe, Sava, Sofia, Vakinankaratra and Vatovavy-Fitovinany) (73% of country total)
 - 80 districts (65% of country total)
- Scope: 822 health facilities; 753 primary health centers (CSBs) and 59 hospitals
- Priority intervention areas: antenatal care (ANC); day of birth care including normal birth, management of complications; postnatal care (PNC) for mothers and newborns; and access to family planning, childbirth, and adolescent sexual and reproductive health.

¹ Immunization was also a key intervention area, though it is not discussed in this brief as it was not part of the baseline evaluation. See all program briefs available on the MCSP website.

² MCSP Madagascar Technical Brief: Improving Quality of Maternal and Newborn Care and Postpartum Family Planning Services

During the first year of project implementation starting in October 2014, MCSP supported the MOH to update MNH, malaria and FP strategies, policies, standards and procedures; capacity building documents (including a training curriculum); and the implementation of various training and supervision approaches. At the national level, MCSP assisted the MOH in developing a favorable MNH policy and implementation framework using evidence-based best practices around birth to reduce maternal and newborn morbidity and mortality. In the second year, MCSP collaborated with the MOH in the initial five start up regions to roll out the training cascade, including the training of trainers, in-service provider trainings and supportive supervision on MNH, malaria and FP technical areas. These trainings included the introduction of a laminated data dashboard poster with MNH quality indicators, which allowed staff from each health facility to visualize and track eight key MNH indicators and develop an action plan to improve care. Data for these indicators were sent via SMS to an online electronic dashboard that was available to MOH staff at the district and regional levels to visualize the indicators and strengthen timely and data-driven decision-making. CG/QI work began during the second year of the project at selected regional referral hospitals, an approach which included the collection of data for 18 quality of care and health outcome indicators. The project expanded to 11 additional regions in Year 3, with the establishment of regional offices. Activities from Year 2 were scaled up in the 11 additional regions. This work continued through project years 4 and 5, with additional work focused around immunization and CG/QI activities at the primary health care level.

Box 2: Key Findings

- Higher knowledge scores in MCSP trained providers compared to providers who had not been trained by MCSP
- Increase in availability of key tracer items for malaria, FP, and BEmONC service delivery
- The use of a laminated data dashboard poster with MNH quality indicators allowed HF staff to visualize and track eight key MNH indicators and develop an action plan to improve care. Interviewees report that the use of data for decision making should be institutionalized
- The MOH should capitalize on the pool of national and regional trainers for implementing interventions at the national and regional, district and facility levels

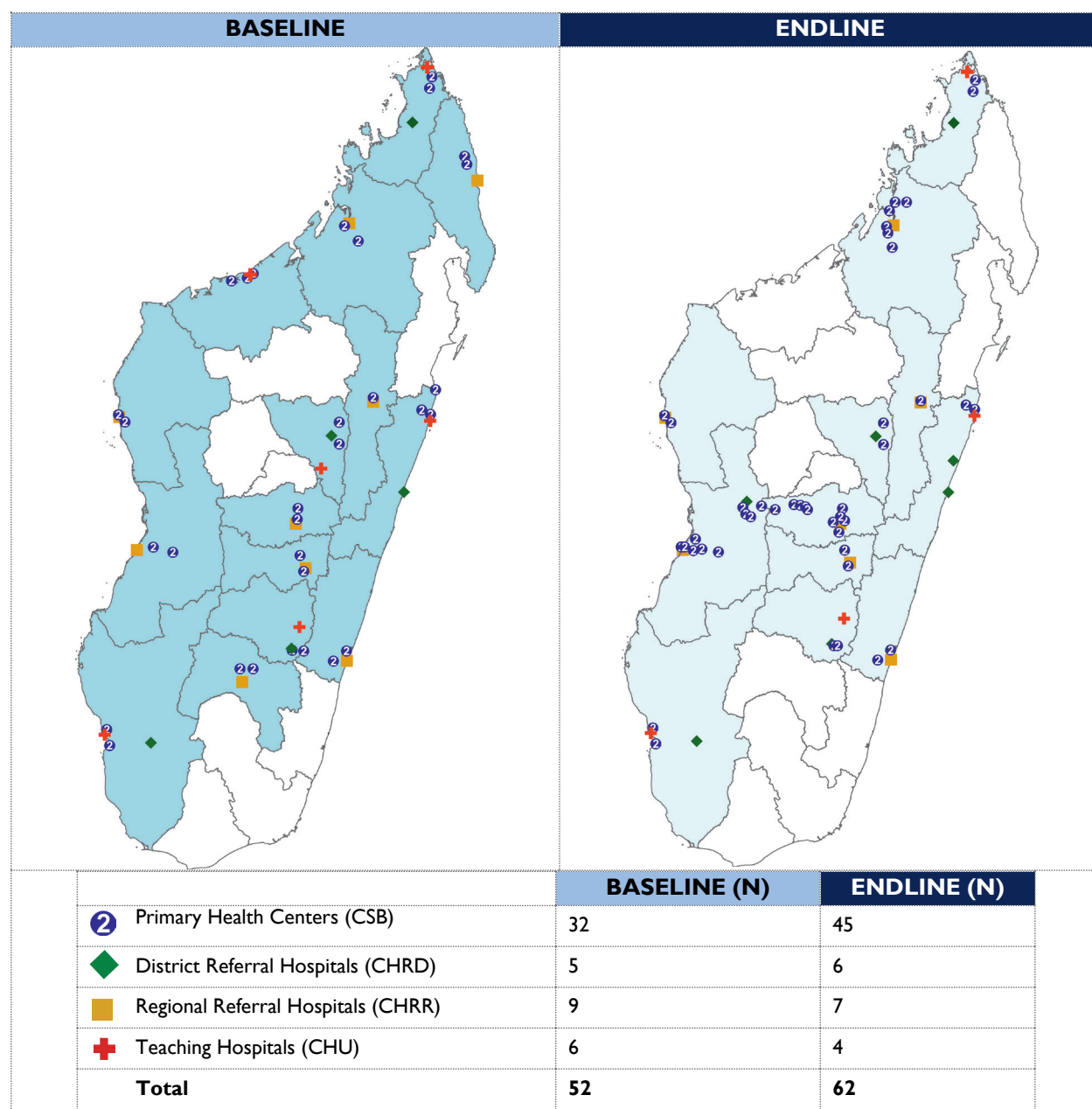
Assessment Objectives and Methodology

MCSP conducted a baseline health facility readiness assessment (HFRA) in 2014 to assess facility readiness to provide reproductive, maternal, newborn and child health (RMNCH) services to inform program design. The assessment used tools adapted from the WHO Service Availability and Readiness Assessment (SARA) and incorporated composite indicators within each service area including the availability of services, trained staff, key commodities, equipment, job aids and visual/auditory privacy to conduct services (Box 3). The baseline assessment randomly sampled 52 facilities at the hospital and primary health center levels (Figure 1). This HFRA was repeated in 2018 using the same tools to document changes in health facility readiness to provide reproductive, maternal, newborn, and immunization services, focusing on areas where key MCSP interventions in MNH, malaria, FP, CG/QI, immunization, and adolescent sexual and reproductive health (ASRH) may have contributed to changes seen at the facility level to provide these services.

Box 3: HFRA Topic Areas

- Availability (and functionality) of equipment needed for ANC, PNC, labor and delivery (L&D), malaria, FP, immunization
- Availability of key commodities needed for ANC, PNC, L&D, malaria, immunization, FP services.
- Number of providers trained in key MCSP interventions including ANC, PNC, L&D, adolescent health, malaria, FP, immunization

Figure 1: Type and location of health facilities sampled in the baseline and endline assessments.



A total of 62 facilities were included in the endline assessment—45 primary health centers (*centre de santé de base*, or CSB), 6 district referral hospitals (*centre hospitalier de reference du district* or CHRD), 7 regional referral hospitals (*centre hospitalier regional de reference* or CHRR), and 4 teaching hospitals (*centre hospitalier universitaire* or CHU) – representing 8% of all 822 MCSP-supported facilities. All 52 facilities from the baseline were included in the endline assessment. The sampled facilities were purposefully selected across 12³ of the 16 implementation regions using the following inclusion criteria: 1) included in the baseline assessment, 2) implemented MCSP-led CG/QI activities, 3) implemented the MCSP-led ASRH intervention targeting young parents called *Tanora Mintsinjo Taranaka* (TMT) and/or 4) were located in MCSP’s targeted districts for immunization activities. Figure 1 presents the type and location of all sampled health facilities for the baseline and endline assessments.

³ The MCSP-supported regions not included were Ihorombe, Analanjirofo, Boeny, and Sava.

For the purposes of the composite indicators, the **Maternal Health** category includes antenatal care (ANC) and labor and delivery (L&D); **Newborn Health** includes essential newborn care, immediate and follow up postnatal care (PNC); **Family Planning** includes out-patient FP and postpartum FP; **Malaria** includes outpatient malaria care and care for pregnant women; **ASRH** includes the training by providers in all service areas on adolescent friendly services and availability of family planning services to adolescents; **Vaccination** includes routine outpatient vaccination; and **Infection Prevention (IP)** covers all facility-wide IP measures.

The endline assessment also included a provider knowledge test for providers from the sampled HFRA facilities working in ANC, L&D, PNC and FP (outpatient and postpartum). All providers present on the day of the survey, regardless of whether they had received training and supportive supervision from MCSP, were invited to participate in the assessment. A total of 99 providers from the sampled facilities met eligibility criteria and agreed to complete a knowledge test.

To explore experiences of providers working at facilities and stakeholder perspectives on MCSP approaches to training, supervision, CG/QI, and other key MCSP approaches, MCSP conducted in-depth interviews with health facility providers and stakeholders at the national/regional/district levels using a structured questionnaire. All providers who completed a knowledge test were invited to be interviewed. Stakeholders were randomly sampled for inclusion in the assessment.

Results and Findings

The final sample included a sample of CSBs and hospitals from all 12 of the 16 MCSP supported regions.

Table 2: Final Sample

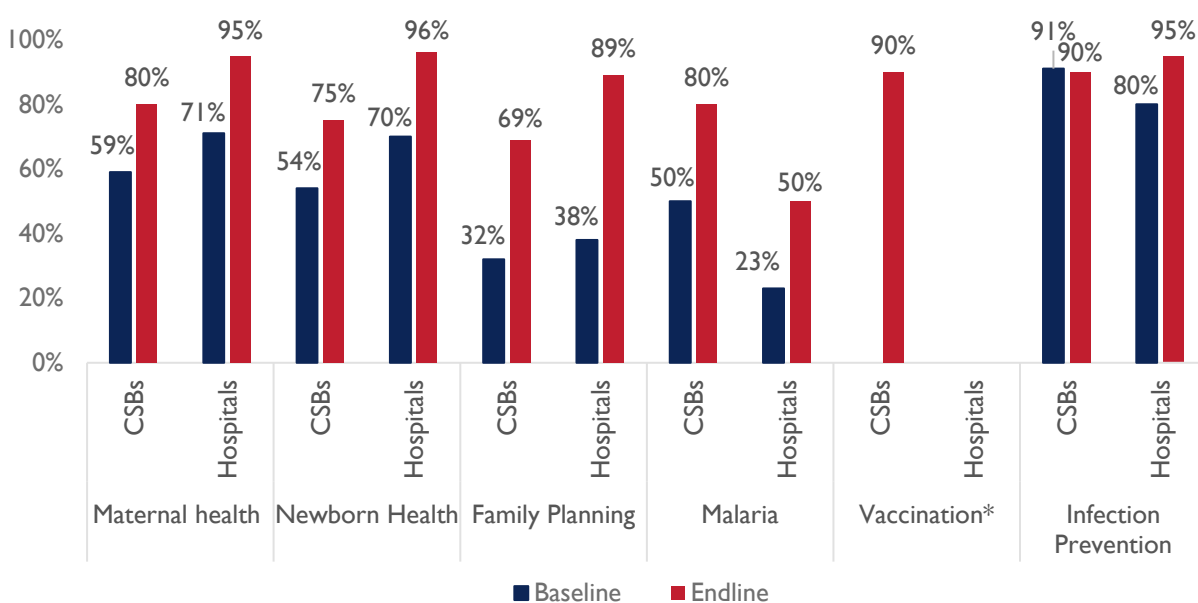
Region Name	HFA		Knowledge Assessment		KII
	# of CSB	# of Hospitals	# of Providers CSB	# of Providers Hospital	# of Participants (regional, district, facility level)
CENTRAL					9
ALAOTRA MANGORO	2	1	5	2	5
ATSINANANA	2	2	3	11	7
AMORON'I MANIA	2	1	3	6	4
HAUTE MATSIATRA	2	2	4	8	2
ATSIMO ANDREFANA	2	2	5	2	5
VAKINANKARATRA	10*	2	16	2	3
VATOVAVY FITOVINANY	2	1	4	3	2
SOFIA	6	1	9	1	3
DIANA	2	2	2	11	5
MENABE	10*	2	0	0	2
ANALAMANGA	2	1	0	0	7
MELAKY	2	1	2	0	5
Total	44	18	53	46	59
Total (CSB and Hospital)	62		99		59

*Vakinankaratra and Menabe sampled additional facilities for a separate data collection effort, results of which are not captured in this brief

Health facility readiness to provide RMNCH services

Health facility readiness composite scores in all areas assessed by MCSP improved or were maintained at high levels in all assessed program-supported CSBs and hospitals (Figure A). For example, health facility readiness scores to provide FP services at hospitals increased from 38% at baseline to 89% at endline. The improved readiness to provide FP services undoubtedly contributed to an increase in the rate of postpartum women adopting a FP method in MCSP-supported facilities from 8% in 2016 to 24% in June 2018, representing 28,204 women adopting a FP method postpartum⁴ throughout the life of the project⁵. Scores on readiness to provide malaria services at health facilities increased from 23% at baseline to 50% at endline, contributing to 93,422 pregnant women receiving at least three doses of intermittent preventive treatment with sulfadoxine-pyrimethamine (IPTp-SP3) during ANC visits over the life of the project in MCSP-supported facilities. Based on CSB dashboard data, the use of IPTp-SP increased from a baseline of 14% (HMIS, 2015) to an average of 28% by June 2018. Furthermore, based on SMS-collected data at MCSP-supported facilities, an average of 99% of suspected malaria cases with positive rapid diagnostic tests (RDT) were treated according to guidelines, including 99,694 children under five. Health facility records also show that 30% of severe malaria cases were referred, showing an improvement from a baseline of 7% (HMIS 2016).

Figure A: Improved health facility readiness to provide MNCH services in MCSP-supported primary health centers (CSBs) (n=45) and hospitals (n=17)



*Vaccination was not included at baseline because it was not part of the intervention package at project start

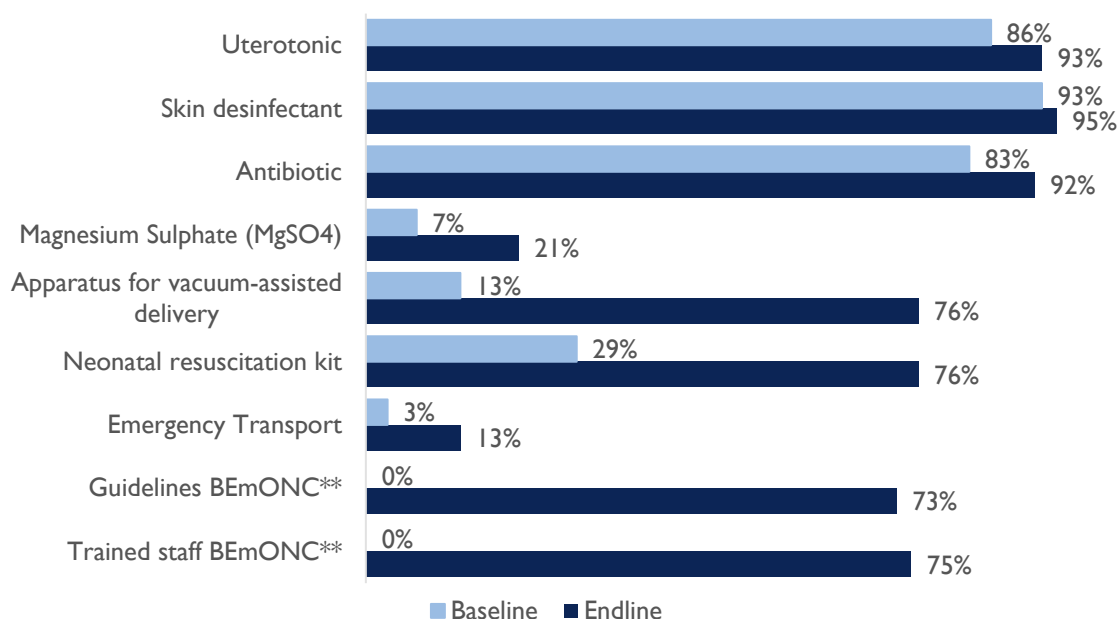
****Composite indicators include the availability of services, trained staff, key commodities, equipment, job aids and visual/auditory privacy to conduct services within a particular domain

Availability of all basic emergency obstetric and newborn care (BEmONC) tracer items improved at MCSP-supported primary health facilities between baseline and endline (Figure B). For example, the availability of injectable uterotonics increased from 86% of facilities to 93% of facilities, and the availability of equipment to perform vacuum-assisted delivery increased from 13% of facilities to 76% of facilities. However, some commodities such as magnesium sulfate remain largely unavailable due to poor supply chain management.

⁴ MCSP Madagascar Technical Brief: Postpartum Family Planning

⁵ This indicator, collected from facility data dashboards, only applies to women who adopt the long-acting methods of IUDs and implants before leaving the maternity ward.

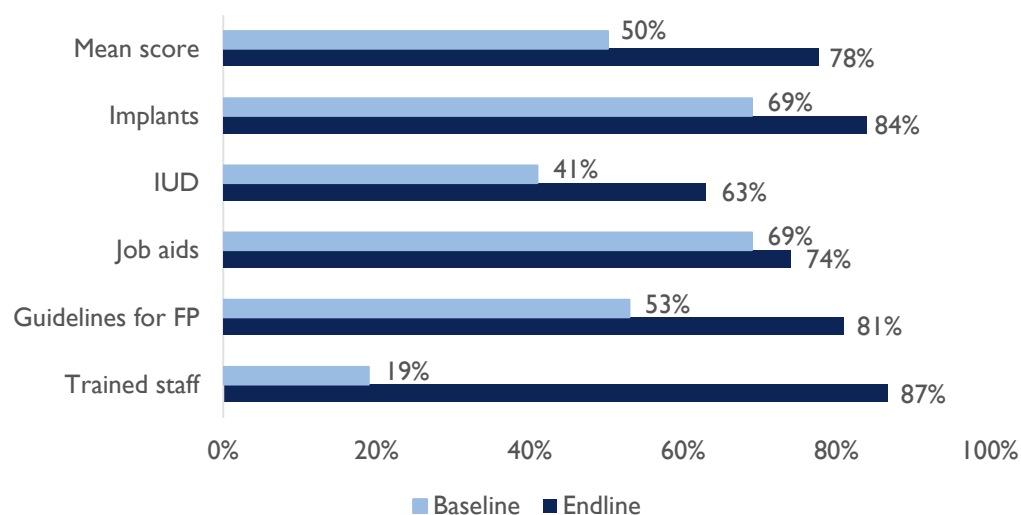
Figure B: Improved availability of BEmONC tracer items in MCSP-supported primary health facilities (CSBs) (n=45)



**At baseline, BEmONC guidelines had not yet been developed and training had not started in facilities

Availability of all tracer items for FP service delivery in CSBs improved from baseline to endline (Figure C). For example, availability of contraceptive implants and IUDs increased from 69% and 41% of facilities at baseline to 84% and 63% of facilities at endline, respectively. Availability of national FP guidelines increased from 53% of facilities at baseline to 81% of facilities at endline.

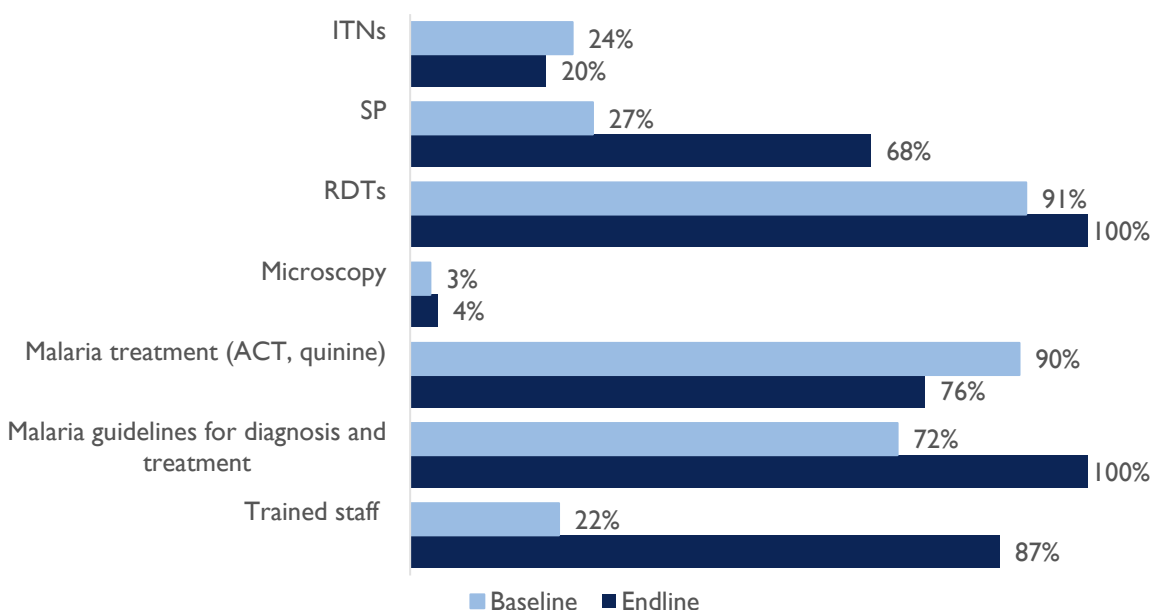
Figure C: Improved availability of tracer items for FP service delivery in MCSP-supported primary health facilities (CSBs) (n=45)



Availability of some malaria tracer items improved in MCSP-supported primary health facilities at endline (Figure D). For example, availability of IPTp-SP increased from 27% of facilities at baseline to 68% of facilities at endline. However, availability of other tracer items such as insecticide-treated nets (ITNs), artemisinin-based combination therapy (ACT), and quinine worsened due to supply chain management challenges, including inaccurate forecasting at the facility level, and delayed distribution of key commodities

from the central to the peripheral facilities. While MCSP did not work directly on supply chain management, it did provide job aids to support facility staff in accurately tracking tracer items to reduce stock-outs.

Figure D: Changes in availability of malaria tracer items in MCSP-supported primary health facilities (CSBs) (n=45)

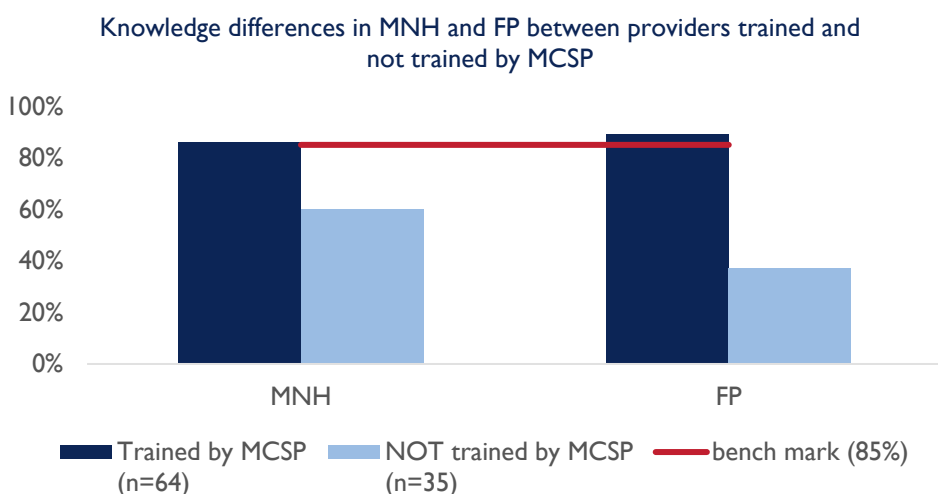


Provider knowledge

The average knowledge score among providers trained by MCSP met or surpassed the target⁶ of 85% in both areas of MNH and FP, compared to providers not trained by MCSP (Figure E). For example, the average MNH knowledge score among MCSP-trained providers was 86%, compared to an average score of 60% achieved by non-MCSP trained providers. Given that the majority of training was completed in the first two years of the project (two years before the endline assessment.), these results illustrate retention of knowledge by providers trained by MCSP. The entire program approach contributed to the retention of knowledge, including the “low dose, high frequency” (LDHF)/supportive supervision capacity building approach and the use of a laminated wallchart to track key quality of care and outcomes measures. The various components of the quality improvement approach also played a significant role including quality committees, structured meetings for data review, action planning and advocacy for available and functional equipment to correctly implement important procedures in MNH, malaria and FP. The contributions of the program interventions to improved and maintained provider knowledge and improved quality of care are discussed in more detail in the sections below.

⁶ The target of 85% was used because it is the score needed [on a post training test] to successfully complete in-service training sessions.

Figure E: Higher average knowledge score among providers trained by MCSP (n=99 providers)



Stakeholder perspectives

Collaboration with the Ministry of Health to support program implementation and sustainability

Key informants at all levels of the health system recognized the vital role MCSP played in improving the quality of RMNCH care, and appreciated the technical, logistical and financial assistance provided by the program. Over the life of the project, MCSP worked to strengthen the capacity of the MOH at the national and subnational levels so that the transfer of key activities and approaches that contribute to sustaining access to and the provision of high-quality RMNCH services could be easily implemented. MCSP staff successfully collaborated with counterparts at the MOH to develop national guidelines, protocols, and job aids, as well as training materials that will continue to be used at the national, regional, and district levels. MCSP trained 33 national trainers and 256 regional trainers across the country who are now equipped to continue training and supportive supervision efforts using the MCSP-developed materials as well as their skills acquired during program activities. Nevertheless, some respondents expressed concern about the sustainability and continuation of program interventions, including training and supervision, and the provision of equipment and medical supplies. For example, facilities and districts had started to establish supervision mechanisms in collaboration with MCSP, but after project closeout, respondents expressed concern that supervision activities will not continue given that they are not budgeted for at the district level. However, other respondents reported that MCSP supported facilities to assign supervisors to continue with supervision activities after the program closes, even if mobile mentorship (e.g., conducting telephone calls between supervisor and provider) is the main source of support.

Clinical Governance/Quality Improvement

In collaboration with regional MOH managers and participating regional referral and district hospitals, MCSP supported the contextual adaptation of the WHO Quality of Care framework standards and measures and MCSP QI principles to the Madagascar context to inform the design and implementation of the CG/QI initiative. At the beginning of the approach, the hospitals defined a set of common measurable improvement aims linked to common quality measures. Each hospital set up a quality improvement committee, which defined an annual action plan to achieve the agreed common improvement objectives defined by the participating hospitals. At endline, interviewed respondents felt that MCSP contributed to significant improvements in quality of care at hospital level. They felt that this was accomplished through several activities, including the presence of quality committees who reviewed dashboard data on quality of care and patient outcomes and worked with providers to improve care. Providers reported that they feel more confident in their clinical abilities and communication style with clients. Respondents also perceived an increased rate of facility deliveries, ANC attendance, and adoption of postpartum family planning methods as the result of renewed focus on quality at the facility level, supported by MCSP. One health district manager

reported that improvements in respectful maternity care at facilities, including the welcoming of husbands during labor and delivery and the ability to choose a birthing position, might be one reason for the improvements seen in the use of facilities by clients.

“MCSP has contributed significantly to the increase in the rate of ANC. Since MCSP, our first prenatal visit has tripled, and the fourth has more than doubled. The program has established an improved way of receiving patients. This gives clients more confidence. Now, the woman is free to choose if she wants to be accompanied by her husband during childbirth, and the birth position. This was not the case before.” – Health District Manager, Diana Region

Some respondents noted a decrease in referrals from lower level health centers to higher-level facilities due to increased capacity and confidence among these lower level facility providers. Other interviewees cited advances in hospital logistics and planning as a result of project led quality improvement efforts.

“MCSP has brought about a major change within the center of the hospital. It has encouraged a climate of organization and planning. The competence laboratory is a very important asset of the project. It just demands better internal organization to ensure sustainability.” – Director, CHU

Dashboards to support data use for decision-making

MCSP initiated the use of data dashboards to display and monitor key indicators on wall posters in supported health facilities. Staff were trained to manually enter indicator values onto the wall chart, using the data to identify gaps or problems that the facility could then remedy. Importantly, more than two thirds of the 822 MCSP supported facilities consistently sent data on a monthly basis throughout project implementation. Action plans were developed in facilities that resulted from data being used for decision making to improve facility level quality of care for patients. Several interviewees mentioned the usefulness of the quality dashboard in helping district level counterparts prioritize supportive supervision with facilities whose dashboard results indicated the most need for support.

“As the person in charge at the Health District level, it is my responsibility to ensure the quality of the services offered by the health centers in my district. Given our means, we are limited in our supervision capabilities. Fortunately, the dashboard initiated by MCSP has effectively equipped us by helping us to prioritize the centers to visit. We can track the indicators for each center from our computer.” – Health District Manager, Analamanga region

An indicator testing activity⁷, which focused on three indicators (successful newborn resuscitation, use of uterotonic after the birth of the baby and pre-discharge postpartum family planning uptake), showed that providers and supervisors found the indicators to be relevant and useful to their work and in their appeal to improving quality of care for patients. The project used the results of testing activity to advocate for the inclusion of the dashboard indicators in the HMIS system. Among other indicators, all of the quality of care indicators introduced with MCSP support were included in the registers and monthly summary reports which was a very important component to the sustainability of indicator use at all levels of the health system. For facilities that did not routinely send data, interviewed respondents attributed the issue to problems with supervision, lack of champions at the facility or district level, and low buy-in from facility leadership.

In the CSB2 in Anjiamangirana, Sofia region, one doctor said she began seeing her work from a different angle after the MCSP training and installation of the dashboard. She was able to reorganize her work and apply acquired skills to solve problems tracked through the dashboard, instead of waiting for support from the higher level. This shows capacity building as providers in smaller facilities feel comfortable to problem-solve.

“After seeing the proportion of umbilical infection at 40% in December 2015, with the color red, I decided to reorganize the ward and keep the mother and newborn for 48 hours after birth for better follow-up. And a clear improvement was found the following months showing always green.” – Doctor, Sofia region

⁷ This brief is still in development

Competency-based “low dose, high frequency” training approach

An adapted low dose, high frequency (LDHF) approach was used to build the capacity of providers in MCSP-supported districts. In response to the MOH restrictions on off-site training, MCSP’s LDHF approach promoted better transfer of learning through on-site training, which allowed hands-on practice. The approach offered brief, targeted facility trainings, which are designed to strengthen the skills of providers at the periphery of the health system using technologies such as mobile telephone, SMS quizzes, and e-learning with the involvement of district facilitators and supervisors as mentors. MCSP’s in-service, LDHF approach was regarded by respondents as a useful and effective capacity building approach. In general, providers agreed that facility-based trainings with shorter, modular training sessions and practical, hands-on methods were preferable to more traditional, classroom-based approaches and were highly beneficial to providers in helping them build, maintain, and supplement their clinical knowledge.

Box 4: MSCP’s approach to Supportive Supervision

Supportive supervision is the “process of guiding, helping, training, and encouraging staff to improve their performance in order to provide high-quality health care services.” The goal of MCSP’s supportive supervision intervention was to improve post-training supervision approaches for health providers by making them more frequent, effective, and practical—especially important for ensuring continuous support for providers located in hard-to-reach facilities. From 2016 to 2018, MCSP supported supervisors in regional and district health management teams to conduct supportive supervision of providers in CSBs and hospitals in nine regions. MCSP trained and equipped supervisors to conduct onsite visits; supported mobile mentoring activities (weekly/monthly structured phone calls, informative texts and quizzes, monthly review of facility data quality dashboard); supported quarterly QI planning; and supported regular data quality assessments.

“Compared to school-based training methods, MCSP’s training approach techniques have given me more practical knowledge.”
– Midwife, Sava region

Providers also felt training on new developments in service delivery protocols was relevant and beneficial. These results mirror the positive results found in a project led supportive supervision activity, where providers and supervisors reported the LDHF and supportive supervision approach to be advantageous in helping health workers provide quality services⁸. The high MNH and FP knowledge scores among trained providers at endline, as compared with non-trained providers, (Figure A), suggests some benefits to the training approach given that it focused on smaller amounts of information spread out over longer periods of time. While most interviewed providers valued the approach, a few respondents mentioned that additional incentives might be useful in maintaining provider participation.

Supportive Supervision

Overall, interviewees gave positive feedback about the onsite visits between supervisors and supervisees that included review of dashboard data, data quality assessments, and action planning. Interviewed providers reported receiving supportive supervision once per quarter (42%), once per semester (38%) and once per month (20%) through either on-site or mobile mentoring. According to most of the interviewed providers, the quality of the supervision they received was “good” and met their expectations. According to the group who thought the quality of supervision was good, supervision has helped to improve or at least maintain skills and has had a very positive impact on the quality of services.

“Supportive supervision reminds us of theories and practices, especially simulation on a mannequin for a small number of [skills]. I forgot most of what we [were] taught in the training room because the volume of lessons [was] too high.” - Provider

However, some respondents felt that onsite supervision was disruptive to their work, as they had to respond to the supervisor rather than carry out usual tasks. A suggested improvement for this was to make the visits shorter (no longer than one day at a time), and increase mobile mentoring with telephone calls once per week.

⁸ MCSP Madagascar Implementation Research Brief: Supportive Supervision

Another suggestion is to share action plans and supervision reports with supervisees so that they are aware of needed improvements and action steps.

Facility providers also noted a general preference for onsite supervision over mobile mentoring (e.g., when a phone call takes place between a supervisor and a supervisee to discuss questions or a particular case).

“Only onsite supervision can improve my knowledge because you can do demonstrations and correct me if I make mistakes.”
– Provider

A regional level respondent also mentioned that MCSP contributed to their knowledge of the methods involved with supportive supervision implementation as well as the planning aspects of the intervention.

“I always learn with MCSP, even the art of conducting supervision, both in its planning and in the methodology itself. However, I have been working for a long time in the Regional Health Directorate.” – Supervisor at the regional health facility, Menabe region

Conclusions

Results from endline analyses of the MCSP Madagascar program show significant improvements in health facility readiness to provide MNH, FP, malaria, vaccination and infection prevention services at both the hospital and the primary health center level. In addition to overall readiness, important advances were seen in specific tracer items for BEmONC and FP service delivery. Assessed at least six months after training, results showed that provider knowledge in MNH and FP was also maintained. MCSP Madagascar’s contributions to the improvements seen in these areas span the entire package of supported interventions. Support at the national level to updates in guidelines and job aids helped improve the availability of up-to-date service delivery guidelines and other tools at the facility level. The LDHF and supportive supervision capacity building approach enabled an environment for learning and team work which allowed providers to improve their skills through direct feedback from supervisors during observations with clients or through practice with anatomical models. These improved skills led to documented advances in quality of care at the facility level, as evidenced in the data collected from quality dashboards. An environment of data use was also fostered through the clinical governance/quality improvement work at the hospital and health center level. Tracking key measures such as ANC attendance allowed quality committees to discuss solutions for facilities that needed further support, which contributed to improved trends in not only key outcome and service delivery data, but in availability of the key commodities that support important interventions. Although the endline assessment did not assess program implementation challenges specifically, it did support the project’s observations that:

- Poor supply chain management leading to stockouts of key commodities had a significant impact on quality service delivery
- Quality of data was a gap that needed to be addressed throughout program implementation
- The management of supportive supervision was a gap prior to MCSP’s intervention. Some providers found it challenging to manage supportive supervision activities on top of their daily tasks, and some supervisors neglected to share corrective action plans.

Going forward, the project hopes that the MOH will use the results of the endline analyses of MCSP Madagascar to continue implementing the approaches that were collaboratively adapted and developed from existing MOH activities. Improving health outcomes for women, children and the families will continue to be possible through government and leadership commitment at all levels of the health system. MCSP hopes that the MOH and partners in Madagascar will take into account the following challenges documented during implementation and recommendations.

Recommendations

- To maintain quality of services:
 - Supportive supervision is crucial, and the MOH should prioritize and budget time for such activities. All health workers, at all levels of the healthcare system should take ownership of maintaining quality services, which includes a cohesive relationship among supervisors and supervisees to share action plans that result from supervision visits and follow-up on those plans.
 - Utilization of data for decision-making through dashboards should be institutionalized and scaled. Rigorous monitoring of indicators will allow supervisors to optimize available resources.
 - The integrated technical approach to capacity building for providers is the most effective
 - The leadership and engagement of MOH managers and providers are essential
 - To improve and maintain quality services, it is necessary to address other problems within the health system: stock-outs, infrastructure, etc.
- Capitalize on the pool of national and regional trainers for the implementation of interventions at the national and regional level
- Strengthening pre-service education is a sustainable investment for the MOH and partners
- Scale-up of the TMT intervention would improve access to health services for a vulnerable population, young parents.

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