

Zambia Health System Strengthening Program (ZISSP)

The Community Health Services Mapping Report



December 2011

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Research Team

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ACRONYMS

ART	Antiretroviral Therapy
BCC	Behavior Change Communication
AIDS	Acquired Immune deficiency Syndrome
CBD	Community Based Distributors
CBO	Community Based Organizations
ACNM	American College of Nurse Midwives
CHAZ	Church Health Association of Zambia
CHWs/CHV	Community Based Workers/Volunteers
CIDRZ	Center for Infectious Disease Control Research in Zambia
CMML	Christian Mission in Many lands
CSS	Community Systems Strengthening
DAPP	Development AID from People to People
DATF	District AIDS Task Force
DHO	District Health Office
DMO	District Medical Officer
EHT	Environmental Health Technician
EmONC	Emergency Obstetric and Neonatal Care
FBO	Faith Based Organization
FP	Family Planning
GMP	Growth Monitoring Promoters
HBC	Home Based Care
HC	Health Center
HCAC	Health Center Advisory Committee
HCP	Health Communication Partnership
HMIS	Health Management Information System
ITN	Insecticide-Treated Net
JICA	Japan International Cooperation Agency
LINCHPIN	Lufwanyama Integrated Neonatal and Child Health Program
MOH	Ministry of Health
NAC	National AIDS Council
NHC	Neighborhood Health Committee
NZ plus	Network of Zambian people living with AIDS
OVC	Orphan and Vulnerable Children
PHC	Primary Health Care
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PPAZ	Planned Parenthood Association of Zambia
SMAGs	Safe Motherhood Action Groups (Target Community group)

STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
ZAMBART	Zambia AIDS Related Tuberculosis Project
ZISSP	Zambia Integrated Systems Strengthening Program
ZANIS	Zambia News and Information Services
ZPCT	Zambia AIDS Prevention, Care and Treatment

EXECUTIVE SUMMARY

The Zambia Integrated Systems Strengthening Program (ZISSP) works in 27 target districts at community level to help community groups advocate effectively for their health needs as active participants in the health planning process. ZISSP also supports communities and local organizations to develop and implement locally-led behavior change and communication (BCC) plans.

As part of the ZISSP implementation process, a community mapping study was conducted to identify existing health structures at all levels and establish gaps especially those related to health service delivery and BCC programs.

The researchers utilized both quantitative and qualitative methods for data collection. The study was conducted in all nine provinces of Zambia. In each province one district was selected using purposeful sampling, bringing the total number of selected districts to nine out of the 27 ZISSP target districts.

Data were collected using standardized questionnaires and interview guides drafted by the study team in consultation with the Ministry of Health (MOH) and ZISSP staff. Data were analyzed using NVIVO version 9 and SPSS version 12.

The most common community groups across all study sites were the Neighborhood Health Committees (NHCs), community health workers (CHWs) and traditional birth attendants (TBAs). Others were home-based care (HBC) givers, lay counselors, malaria control agents and TB supporters. Generally the NHCs and TBAs were the most active community groups based on report submissions and observed activity in the community.

Partners were largely dependent on the district visited though some partners appeared to be in more than one district for example Center for Infectious Disease Control Research in Zambia (CIDRZ) was noted in Kalomo, Lukulu and Luangwa. The District AIDS Task Force (DATF) office was found in all the districts visited though they were usually mentioned after probing in many districts. The Catholic Church was the most common faith-based partner and worked in the area of Orphan and Vulnerable Children (OVC) support. The study noted that most of the partners worked in the area of HIV/AIDS.

All the health centers visited had a Health Center Advisory Committees (HCAC) in place. However, the level of involvement differed greatly from facility to facility, with some HCACs being very actively involved in the running of health centers while others existed in name only and rarely met.

In terms of gender representation in the HCAC, the results showed a tendency for male dominance. For example, all the chairmen of HCACs were men, while the secretary position was dependent on the sex of the health center in-charge, as this is a reserved position for the health center. In the 27 health centers surveyed, 3 from each district, a total of 351 HCAC members were identified, 230 were male and 121 were female, giving a male to female ratio of 2:1. The major roles of HCAC could be summarized into three: 1) link between the health center and the community, 2) facilitator of collecting and presenting community information, and 3) acting as an advisory body to the health center on community issues.

About participation in the planning process, the study showed that the District Health Office (DHO) and health centers participated actively in the planning process. They were aware of their roles and responsibilities and were updated with the planning requirements and time lines. However, this was not the case at the community level, where apart from NHCs and CHWs in some health centers most of community groups denied taking part in the planning process.

Some challenges in the planning process cut across all levels of administration while others were specific to particular levels of administration. Some common challenges included limited funding for the planning process, limited time to conduct extensive consultation with key stakeholders and lack or high turnover of

trained human resources who were familiar with the planning process. It was a general concern that funds allocated to the planning process were limited at all levels thereby making it difficult to plan properly.

In terms of participation of community groups in the use of resources, the findings indicate that very few health centers had formal meetings with the HCAC or NHCs to discuss how the received imprest and resources were to be allocated. In all the health centers none of the community groups had ever received cash. They only received resources in kind as the HCACs and NHCs believed or felt they could not entrust the communities with cash. Most health center managers feared that community groups could not account for cash if it were given to them. It was unclear how the 10% allocated to community activities was used therefore. The findings point to the fact that some of the community resources were actually used by health center staff as allowances or fuel, for example, rather than on actual activities in the communities. Generally, there were no clear plans at either the health center or community level to ensure that resources intended for use are actually tracked to make sure they are used for the intended purpose.

On health services, the results showed that most health services were offered in targeted districts. However, the coverage and quality of some services were very poor. It was noted that health centers far away from the district had challenges accessing emergency obstetric and neonatal care (EmONC). In addition, lack of trained health human resources and essential drugs hindered provision of quality health care especially in rural health centers.

In all the study districts, the commonly available BCC materials were brochures, booklets and leaflets. These were mainly supplied by partners and the DHO. Most of the materials focused on HIV/AIDS.

Most of the BCC materials were displayed at health centers. None of the participating community groups distributed any BCC materials except for a few irregular supplies during national campaigns like child health week. Almost all BCC materials were in English language.

Coordination of BCC activities was very poor with most cooperating partners working parallel to the DHO. In some cases the DHO was unaware of what BCC material and activities were being carried out by partners in the district. This was attributed to lack of a focal person in-charge of BCC at the district level.

Data were collected on the availability of tools for collecting community level health information. The findings showed that almost all community groups had no data collection tools except for a few groups supported by partners.

The most influential and active local leaders were traditional leaders. These included village headmen and some local chiefs. They acted as a catalyst in integrating new health programs when introduced in their areas.

In summary, the study achieved its objective of mapping existing community resources in selected districts highlighting opportunities and challenges at all levels of service delivery. It revealed the current state, potential and capacity for health service delivery and highlighted major challenges hindering the potential to deliver quality health care.

General recommendations:

- 1) Many community groups and partners existed in the study districts. However, coordination among the actors was very poor.

The study recommends building coordination capacity at the DHOs to coordinate the activities of various community groups and partners working in the districts.

- 2) Generally, the planning process was being hampered by limited funding and time to allow for adequate planning at all levels.

There is need to increase funding for planning at all levels and ensure that enough time is allocated for community participation in the planning process.

- 3) Though many community groups were willing to contribute to health service provision, they generally lacked capacity and materials to carry out their work.

It is therefore recommended that priority be given to building capacity for community groups and to providing them with basic materials to carry out their work effectively

- 4) The study noted that representation of women in leadership position at the community level was very low.

It is recommended that priority be given to gender issues with deliberate efforts to encourage participation of women in leadership especially at community level.

- 5) Many community volunteers were discouraged or unmotivated and working below capacity. This was attributed to lack of incentives and resources to carry out their work.

There is need for the MOH and its cooperating partners to consider various options to motivate community volunteers including providing training, certification, identity cards and small allowances depending on feasibility and availability of resources.

- 6) Though most health services were available in many communities, the coverage and quality were poor for many of the services. This was primarily attributed to among other things, lack of trained health human resource.

It is therefore recommended that MOH and its cooperating partners provide incentives for recruitment and retention of trained health workers especially in rural areas.

I BACKGROUND

I.1.1 Introduction

As Zambia strives to achieve multiple health goals to ensure all citizens have access to health care, multiple actors and partnerships are needed. In this context, community-based organizations (CBOs) have become a critical component of the extended health care system in many countries. CBOs are defined as organizations that have arisen within a community in response to particular needs or challenges and are locally organized by community members. In many countries and contexts, CBOs are the only agencies able to reach the most hard-to-reach individuals. However, many CBOs face chronic resource constraints which can limit the extent and scope of the important work they do. They often need not only greater and more consistent financial assistance, but also assistance to increase the skills and capacities of current and future personnel. Policy-makers, donors and multilateral agencies around the world increasingly recognize that public health in many low income countries could be improved and expanded by helping build such skills and capacities within local civil society groups, a concept known as community systems strengthening (CSS). Community systems' strengthening is an approach that promotes the development of informed, supportive communities and community-based structures, enabling them to contribute to longer-term sustainability of health and other interventions at community level.

The Zambia Integrated Systems Strengthening Program (ZISSP) is a 4.5-year task order contract which was launched in 2010. ZISSP is designed to increase use of high-impact public health interventions at district and community levels, through a health systems strengthening approach. Technical program staff work intensively at all levels of the health system – national, provincial, district and community – in collaboration with the Zambian MOH and public and private sector stakeholders to build capacity for delivery and uptake of quality health services. Key to the successful implementation of ZISSP is creation of sustainability through promoting and strengthening Zambian leadership and ownership of program interventions at all levels. The ZISSP areas of clinical and technical focus include HIV/AIDS, malaria, family planning, maternal, newborn and child health and nutrition. The program promotes integration of policies, resources and service delivery systems across these interrelated sub-sectors of health care. As a result of ZISSP interventions, more families and individuals in the most vulnerable districts in Zambia will have access to the services and information required for them to attain and maintain good health. ZISSP is implemented by Abt Associates, in partnership with the Planned Parenthood Association of Zambia (PPAZ), the American College of Nurse Midwives (ACNM), the Johns Hopkins University Center for Communications Programs (CCP), Banyan Global, Akros Research, the Liverpool School of Tropical Medicine and BroadReach Institute for Training and Education (BRITE)

At community level, ZISSP works in the 27 target districts to help community groups to advocate effectively for their health needs as active participants in the health planning process. ZISSP also supports communities and local organizations to develop and implement locally-led BCC plans. The project supports specific aspects of the community health worker program, in particular the improvement of systems to forecast for and reliably deliver essential supplies that the workers need to provide health services to their communities. Work at the community level is expected to be implemented partly through a grants program for non-governmental organizations (NGOs) engaged in community-based health and BCC programs.

The MOH in collaboration with ZISSP proposed to conduct a community mapping study as a strategy to identify the existing health structures, facilities, groups, partners and their roles, areas of focus, operational areas, strengths and weaknesses and identify the gaps existing in the communities especially those related to health service delivery and communication programs in selected districts. The results of this exercise were to help in developing strategies for strengthening participation of the community in health planning and to strengthen implementation of effective health communication and behavioral change programs at community level.

Mapping is a methodology used to link community resources to fit into the organizational goals, strategies, or expected outcomes. There are several principles that are unique to guide the mapping efforts. The

mapping strategies focus on what is already happening in the community in terms of health service provision. The idea is to build on the strengths within a community. It is anticipated that this mapping exercise will result into developing partnerships and help to achieve the organization's goals.

1.1.2 Specific Objectives:

- 1) Identify the existing structures of the community groups and other organizations implementing health related services in the community.
- 2) Asses the roles and program focus area for the various groups and partners.
- 3) Identify synergies and /linkages between the community groups and service providers.
- 4) Identify potential areas of intervention for scaling up the services.
- 5) Identify strengths, weaknesses and gaps in the current program areas (family planning, malaria, child health, reproductive health, adolescent health, and EmONC).
- 6) Identify gaps in the availability, access, distribution channels and relevance of community-based BCC materials and suggest ways of addressing these gaps.

2 METHODOLOGY

The community mapping study utilized both quantitative and qualitative methods in data collection. Most of the information was collected using qualitative methods because of the nature of the information which required probing and explanations from respondents. In addition, a quantitative method was used to collect information related to demographic characteristics of the participants and the study sites.

2.1 Target Groups

The target groups were managers at the DHO and health center levels. At community level the target groups were leaders and members of the NHCs, Save Motherhood Action Groups (SMAGs), and any other community-based and faith-based organizations. At provincial level, the health promotion officers were interviewed about BCC. Three teams were involved with each data collection team visiting three provinces and districts. In each district the research team first paid a courtesy call to the DHO and then proceeded to make arrangements with selected health centers. Once at the health center, the teams met with the in-charge who helped to organize the community groups. In some places groups were informed prior to the arrival of the research team. This was the best scenario. In some cases the research team had to start organizing community groups upon reaching the health centers. At each health center, interviews were conducted with the health center manager. In addition, two to three community groups were interviewed depending on the number of available groups at the health center. In total 18 in-depth interviews were conducted. Nine in-depth interviews at district level and nine at health center level with respective managers and their teams. At community level a total of 62 focus group discussions (FGDs) were conducted with different community groups (See Annex 8.3 for details).

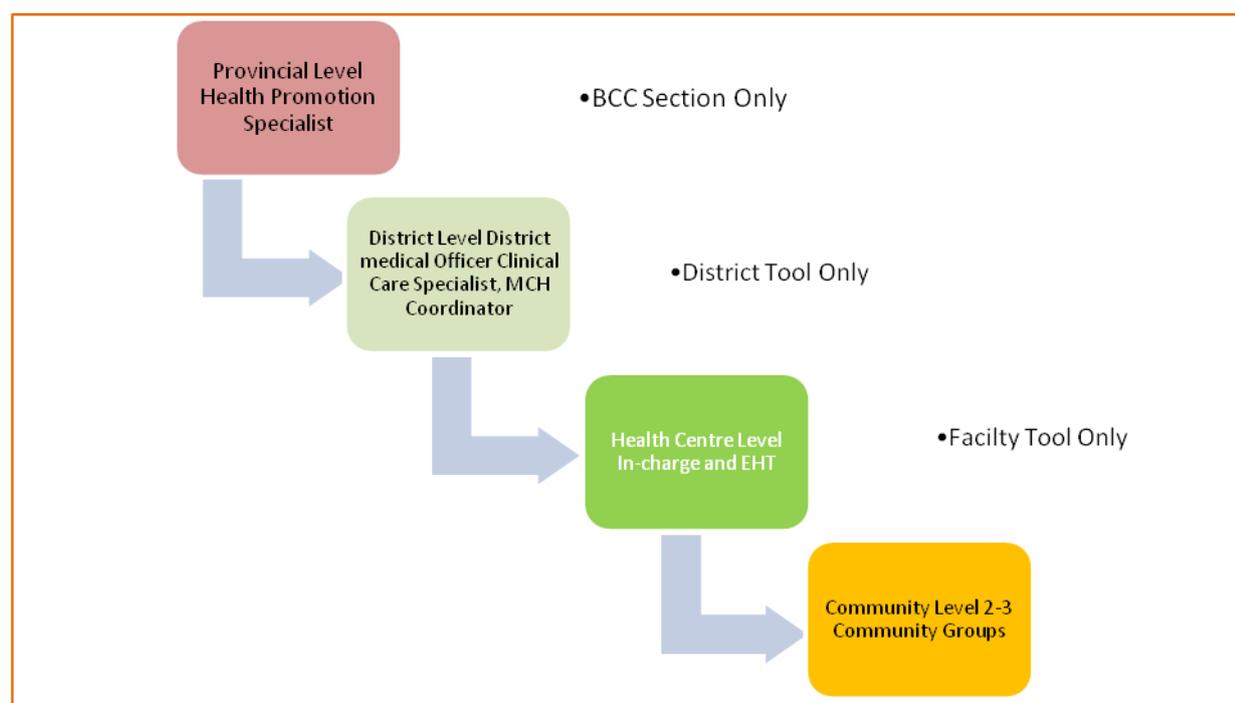


Figure 1 Flowchart Selection Criteria for Study Participants

2.2 Study Sites

The study was conducted in all nine provinces of Zambia. In each province one district was selected using purposeful sampling, bringing the total number of selected districts to nine out of the 27 target districts for ZISSP. The selected districts were: Chiengi (Luapula Province), Kalomo (Southern Province), Lukulu (Western Province), Lufwanyama (Copperbelt Province), Mbala (Northern Province), Nyimba (Eastern

2.4 Data Management

All the recordings were validated by team leaders and the consultant. The data collected were transcribed by nine research assistants who were part of the data collection team. The consultant and the team leader verified all the transcriptions.

2.5 Data Analysis

Qualitative data were analyzed using NVIVO version nine where identification of themes followed the conventional coding process. The results were combined and subsequently collated into relevant, larger thematic categories to improve the explanatory ability of the data. Quantitative data were analyzed using SPSS version 12 for Windows.

2.6 Ethical Consideration

This study obtained approval from the MOH. Because it was an operation within the MOH, it was exempted from being reviewed by the Ethics Committee. However, all ethical principles of conducting research were followed. The names of individual participants were not used except on the consent form. During FGDs each participant was given a unique identification number. Consent forms were kept under lock and key and accessible only to the study Principal Investigator. All electronic data were protected with a password known only to the Principal Investigator. All participants were provided with information about the study. Confidentiality was assured during the data collection process and subsequent report writing and publication. All those accepting to take part were asked to sign a consent form. Those who were unable to write were asked to thumb print the consent form in the presence of an independent witness.

3 STUDY FINDINGS

The results of the study undertaken are described below.

3.1 Community Groups and Partnerships

Providing good health services in communities requires efficient use of available resources. Identification of active community groups and partners is the starting point in mapping community resources. Early recognition of community networks, linkages and partnerships is crucial in ensuring successful community engagement. This results in shared approaches, advocacy initiatives and appropriate representation of community needs in relevant fora. Strengthening formal and informal relationships enables more effective use of resources and avoids unnecessary duplication of work. The community mapping study collected information about community groups and partners existing in the target districts as a way of identifying existing resources and linkages at community level.

3.1.1 Community groups working in target districts and communities

The results showed that the most common community groups across all study sites were NHCs, CHWs and TBAs. Others were HBC givers, lay counselors, malaria control agents and TB supporters. The Network of Zambian People Living with AIDS (NZ plus) existed in Zambezi district only. SMAGs were found in Chiengi, Mbala, Lufwanyama, Kalomo and Zambezi which corresponded to the districts where SMAGs were launched earlier by the MOH. Generally the NHCs and TBAs were the most active community groups based on report submissions and observed activity in the communities. The SMAGs were said to be active only in Mbala district (See table I below).

Table I Community Groups Working In Selected Districts

District	Community groups	Most active currently
Chiengi	NHCs	NHCs
	TBAs	Lay counselors
	CHWs	CHWs
	SMAGs	TBAs
	Malaria control agents	
	TB treatment supporters	
	Lay counselors	
Lufwanyama	NHCs	NHCs
	CHWs	TBAs
	Peer educators	
	Adherence supporters	
	SMAGs	
	TBAs	
Nyimba	NHCs	TBAs
	CHWs/community-based volunteers	NHCs
	Adherence supporters	
	Lay counselors	
	Growth monitoring and promoters	
	Malaria control agents	
	Nutrition group	
	TBAs	

Kalomo	CHWs	TBAs
	NHCs	NHCs
	Adherence supporters	
	SMAGs	
	Lay counselors	
	Anti AIDS club	
	Nutrition group	
Lukulu	NHCs	NHCs
	HBC givers	HBC givers
	CHWs	
	Sisters of Lilato (Catholic)	
	Hen hood (new apostolic)	
Kapiri Mposhi	CHWs	NHCs
	NHCs	Lay counselors
	Malaria agents	
	TBAs	
	Lay counselors	
	Growth monitoring promoters	
Mbala	NHCs	CHWs
	HBC givers	TBAs
	TBA/community-based birth attendants (CBBA)	NHCs
	TB supporters	SMAGs**
	Growth monitoring promoters	
	Malaria agents	
	SMAGs	
Luangwa	HBC givers /home-based volunteers (HBV)	
	NHCs	NHCs
	TBAs	TBAs
	Community-based distributors (CBDs)	CHWs
	CHWs	
Zambezi	NHCs	NHCs
	CHWs	CHWs
	NZ plus	TB supporters
	SMAGs	NZ plus
	TB supporters	

3.1.2 Partners currently working in selected districts

Partners were largely dependent on the district visited though some partners appeared to be in more than one district, for example CIDRZ was noted to be in Kalomo, Lukulu and Luangwa. The District AIDS Task Force (DATF) office was found in all the districts visited though they were usually only mentioned after probing. Other partners found in more than one district were Zambia AIDS Prevention, Care and Treatment (ZPCT), Society for Family Health (SFH), World Vision and Boston University. Boston University was found in Lufwanyama and Kalomo. The Catholic Church was the most common faith-based partner and

worked in the area of OVC support. The study noted that most of the partners worked in the area of HIV/AIDS. For example CIDRZ, ZPCT, Boston University, and the Japanese International Cooperating Agency (JICA) were providing ART and PMTCT services. World Vision supported a number of activities including support of some community groups in Chiengi, Kalomo and Nyimba and also provided water and sanitation service. SFH provided family planning services. The study showed that most partners worked in isolation and supported different community groups (see annex 8.1).

3.2 Composition and Roles of the Health Center Advisory Committee

The MOH recommends that each health center elects an HCAC from various neighborhood committees in the catchment area with the health center being the secretariat. This body is expected to play an advisory role to the health center with the aim of representing the interests of the community. As part of this study data were collected to establish whether each health center visited had an HCAC in place and to establish the gender composition and the actual roles of HCACs.

The findings showed that all the health centers visited had an HCAC in place according to the health care workers. However, the level of involvement differed greatly from facility to facility, with some HCACs being very actively involved in the running of the health center. This was noted at Nkana Health Center in Lufwanyama and Bhoma Health Center in Luangwa district. In contrast, other HCACs existed in name only and rarely met. This was the case at Chifunsa Health Center (Kalomo district) and Lubosi Health Center in Lukulu district.

3.2.1 Gender analysis of the Health Center Advisory Committee

It has been recognized by both the health workers and the community group workers that gender inequalities affect access and utilization of health services. This is worse in rural communities where gender roles tend to favor men at the expense of women. Hence the current strong advocacy effort by the community groups to have gender representation at all levels of health service delivery so that women could play their role in improving health in their community. Gender integration is equally fundamental to the implementation of ZISSP activities. Therefore gender analysis becomes a vital step to achieving this objective.

In this study, the gender composition and roles of HCAC were explored. The results showed a tendency for male dominance in the composition of the HCAC. For example, all the chairmen of the HCACs were men, while the secretary position was dependent on the sex of the health center in-charge as this post was reserved for whoever was in-charge of the health center. Women tended to be mostly committee members and treasurers in a few cases. Out of 351 HCAC members recorded in the 27 health centers, 230 were male and 121 were female, giving a male to female ratio of 2:1

The average percentage of female representation in the HCAC was 34.5%. In most of the districts the female representation ranged between 30 and 40%. Kalomo and Lufwanyama had the highest female representation (40%) while Mbala had the lowest. (See Table 2)

Table 2 : Health Center Advisory Committee Composition by Gender

	TOTAL	MALE	(%)	FEMALE	(%)
Chiengi	36	25	69.4	11	30.6
Kapiri Mposhi	69	48	69.6	21	30.4
Lufwanyama	45	27	60.0	18	40.0
Kalomo	35	21	60.0	14	40.0
Nyimba	33	21	63.6	12	36.4
Lukulu	38	24	63.2	14	36.8
Luangwa	43	28	65.1	15	34.9
Mbala	27	20	74.1	7	25.9
Zambezi	25	16	64.0	9	36.0
TOTAL	351	230	65.5	121	34.5

Box 1:

“Usually women are lazy to participate in these activities. Especially in rural areas, you find that men are the ones that are active,” reported a health center manager from Luangwa.

3.2.2 Roles of the Health Center Advisory Committee

The study collected information about the role that the HCAC played in health service delivery in their communities.

According to the health care workers and the different community groups the major role of the HCAC could be summarized into three which include

1. Providing a link between the health center and community
2. Facilitating collection and presentation of community information,
3. Acting as an advisory body to the health center.

The HCAC was seen by the health care workers as a link which brought the health center and the community together. At the health center level, the HCAC participated in making action plans and provided necessary community information used in the planning process (though this was not done in all the health centers) At community level, members of the HCAC were usually chairpersons for their respective NHCs. The main role was to gather health information and views from the community. Once information was collected at community level through the NHCs, this information was passed on to the health center and discussed during HCAC committee meetings. Once a decision and programs were mutually agreed upon, the HCAC provided feedback to the community through their respective NHCs. The HCAC also acted as an advisory body to the health center. They usually met once per quarter to discuss problems identified in the communities and provided input in finding solutions to the challenges in their communities.

Interestingly, most health center managers who responded to this question rarely mentioned the involvement of the HCAC in the planning process except after probing about this issue specifically.

It was also reported that there was no manual which described the roles of HCAC or NHC members so the above roles were assumed rather than prescribed.

Box 2:

*"The health center advisory committee acts as a link between the health center and the community. If the community has problems, they come and present them at the health center and then we work on that....."*Health Center Manager Chiengi.

"The HCAC usually helps us identify problems in the community. After identifying the problems through the Neighborhood Health Committee, they help us in looking for solutions. We sit in quarterly meetings and come up with better solutions to help our community." An EHT, Zambezi.

"We do not have a training manual for NHCs. We just instruct them on what needs to be done," Health Center Manager Lufwanyama.

3.3 The Planning Process

Effective planning is cardinal to the realization of the objectives of the national development plan as well as the National Health Strategic Plan. Though the MOH has provided planning guides and information to health centers/health posts and communities to use in the process of developing action plans, the major challenge has been the low involvement of the community in planning health services which is a crucial step in the planning process. According to the MOH recommendations, the planning process can be broken down into five stages.

The first stage involves the DHO meeting with the health center in-charges and health post officers to provide information about planning guidelines and the budget ceilings. This information is crucial for health center and health post staff to complete their action plans.

Critical to this process is the second stage where the health center or health post staff meets with representatives of the communities they serve and CBOs. This is done through the HCAC or through other community organizations working with the health center.

The third stage is at community level where NHCs meets with community members and influential community leaders. The main purpose of this stage is to solicit the participation of community members and community-based agents in deciding and prioritizing what to include in the next action plan for the health center.

The fourth stage brings together the health center staff and the community representatives. This forms the HCAC which discusses the submissions from the community and then finalizes the drafting of the health center action plan. Costing of the community action plan is completed at this stage.

The fifth and final stage of the planning process brings together the DHO and health centers/health posts, hospitals, health training institutions, NGOs and other stakeholders, to share the outcomes of lower level planning and identified priorities. The district facilitates stakeholder inputs into the district plan and agrees on the district wide objectives. Health centers and health posts present the draft action plans.

3.3.1 Participation in the planning at all levels

One of the key objectives of the community mapping was to establish the role of the community groups in the planning process of health services. The findings showed that the DHO and health centers participated actively in the planning process. They were aware of their roles and responsibility and were updated with the planning requirements and time lines. However, this was not the case at community level. Apart from NHCs and CHWs in some health centers, most of community groups denied taking part in the planning process. Some community groups which indicated that they were not involved or consulted in the planning process included TBAs, SMAGs, lay counselors, malaria agents, HBC givers and CBDs. Nonetheless, most of the groups indicated that they submitted activity reports to health centers. Table 3 gives a summary of the roles played by the district, health center and community groups in the planning process. The district provided technical support and played a leading role in facilitating development of action plans. This involved coordinating the participation of health centers and other stakeholders in the planning process and soliciting their input. It was the responsibility of the district to develop the final action plan and submit it to the provincial health office and to provide feedback to the health centers and stakeholders about what activities were approved.

The major role of the health center in the planning process included facilitating collection of community health needs and suggestions which were to be included in the action plan. Other roles included priority setting and drafting of the action plan for submission to the district. This was done in collaboration with the local HCAC members in some places.

Box 3:
“Right now we are coming from the planning launch, so we need to call at least one person from each health center to brief them about the latest updates and provide them with planning ceilings.”(DMO)

Box 4:
“Every year, the health center staff asks us to provide information for inclusion in the action plans. So we sit down with our community members to come up with priorities and bring them to the health center. The health center combines submissions from all NHCs and comes up with the final action plan. That is how we get involved in the planning process.” (NHC member Lukulu)

However, not all the health centers involved the HCAC or other community groups in the planning process. The general picture was that the majority of community groups never participated in the planning process and was rarely consulted. Interestingly some of them routinely submitted monthly or quarterly reports even when they were aware that their suggestions were never considered when the final action plan was being made by the health center.

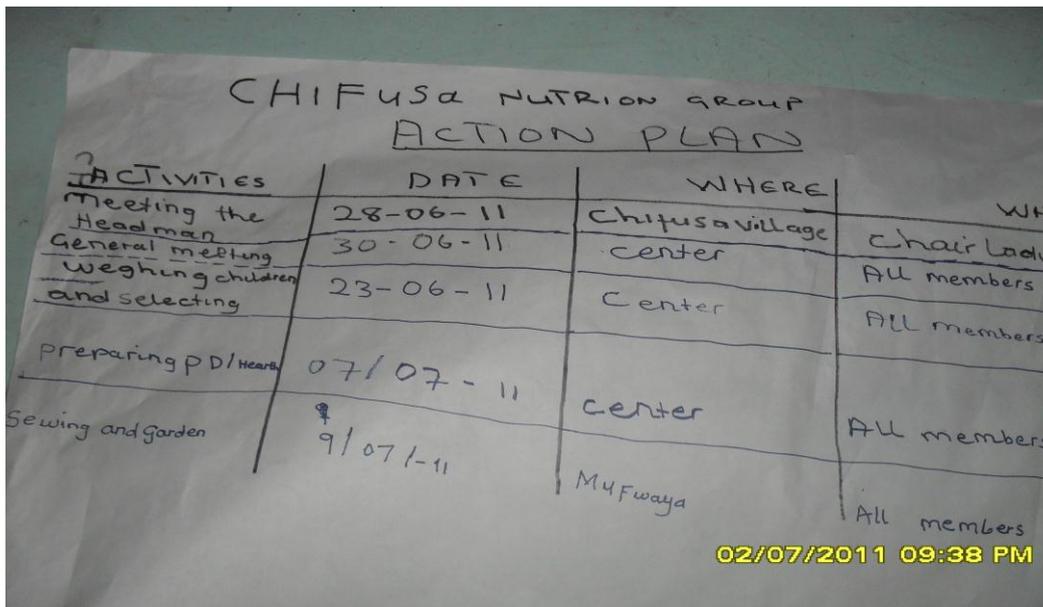
Box 5:
“We are not involved in the planning process. We used to make action plans some time back but not anymore. We are not invited for planning meetings. We just find that action plans have already been made.” (NHC Member, Mbala)

Table 3: Participation in the Planning Process

Level of health care	The extent of participation	Role in the planning process
District	All the districts visited participate in the planning process	1) Acts as a key leader in facilitating the planning process in the whole district 2) Provides information about the time table of planning to

		<p>health centers and partners</p> <ol style="list-style-type: none"> 3) Makes logistical arrangements for the launch of the planning process in the district 4) Calls for meetings to orient health centers and partners about the planning process especially on the importance of adhering to ceiling figures and gives manuals to guide the planning 5) Facilitates coming together of health centers and partners for making the district action plans based on health center action plans 6) Helps in prioritizing issue/items to include in the final district action plan 7) Helps in costing the items included in the final action plan 8) Submits action plans to the province 9) Gives feedback to the health centers about what was submitted to the province 10) Oversees the implementation of the action plans in the districts
Health center	All the health centers visited participate in the planning process	<ol style="list-style-type: none"> 1) Is a key facilitator of the planning process at health center and community level 2) Informs community groups about the planning cycle timelines 3) Facilitates meeting of community groups at the health center 4) Collects information/issue submitted by community groups (mostly NHCs) 5) Is part of the HCAC which makes the final action plans for the health center based on community needs 6) Attends planning meetings at district level 7) Submits health center action plans to the district for consideration 8) Gives feedback on approved activity to community groups 9) Oversees the implementation of health center action plans
Community groups		
Neighborhood Health Committee	Some of the NHCs visited participate in planning process	<ol style="list-style-type: none"> 1) Is the main link between community and health center 2) Collects information about community problems and concerns 3) Participates in prioritizing the needs in the community in consultation with community members and other community groups 4) Submits list of problems to the health centers 5) Through the HCAC participates in drafting the health center action plans 6) Oversees implementation of approved activities in the community in collaboration with other community groups
Community health workers	Some of the CHWs participate in the planning process to a limited extent	<ol style="list-style-type: none"> 1) Submit reports to the health centers about their activities 2) Sometimes submit reports to NHCs for consideration 3) Participate in identifying community problems based on their daily work
Traditional birth attendants	No	Just submit activity reports to health center
Safe Motherhood Action Groups	No	Just submit activity reports to health center
Lay counselors	No	Just submit activity reports to health center

Malaria treatment supporters	No	Just submit activity reports to health center
Home based care givers	No	Just submit activity reports to health center
Community-based distributors	No	Just submit activity reports to health center
Other groups	No	Irregular submission of reports to health center



Sample of action plan at Chifunsa Health Centre in Kalomo

Figure 2: Sample of action plan used by a community group at Chifunsa Health Center in Kalomo

Figure 2 shows a picture of an action plan posted on the wall at Chifunsa Health Center in Kalomo district by a community group supported by a partner. This group provided nutrition support to the community within the Chifunsa catchment area. The group developed its own action plan which they shared with the supporting partner and displayed it at the health center for all to see.

3.3.2 Planning guidance and training given to community groups by the health center

The study was interested in finding out whether community groups were given guidance or training in relation to the planning process in general and specifically in BCC. A two pronged approach was used to collect this information. The managers at district and health center level were asked about their views in relation to guidance on the planning process. At the same time community groups were asked if they had received any guidance or training with regard to the planning process.

It was interesting to note that the answers were dependent on the type of respondent. While most health center managers felt that they provided guidance and training to the community groups, most community groups disagreed with such assertions and insisted that they were never given any guidance or training by the health center in the planning process, though in Zambezi, one health center manager acknowledged that training of community groups was never provided in the area.

In a few places training was provided to community groups by some partners. This was noted in Lufwanyama

and Kapiri Mposhi where some partners were training the community on how to make action plans.

It was noted that most of the training received focused on general health related work done by specific groups and organized according to partner needs rather than community needs and was usually done at the beginning of programs without any follow up. It was evident that training on BCC was rarely done for community groups.

Box 6:

“We teach them about diseases and planning. They need to know how to do the costing and set priorities.” Health center manager, Chiengi

“We give them guidance on the timeframe, and we also sketch a plan so that they can see how they are meant to plan,” Health center manager, Kapiri Mposhi

“On training I would say there is nothing. We have been asking for assistance from the district but nothing comes so it becomes difficult for us to do any training for community groups,” Health center manager, Zambezi

“We haven’t received any training this year. We only had one training just at the beginning,” SMAG member, Mbala

“We have never been trained by the health center. We only received training from Development Aid from People to People (DAPP),” TBA member, Kapiri Mposhi

3.3.3 Priority setting: why some items were not included in the action plan

The respondents were asked to provide reasons why some of the suggested items were not included in the action plans. The responses were stratified by level of health care. The most frequently cited reason given was limited resources. This was rated high at district and health center levels as the main reason why some of the activities were not included in the action plan. The fact that the government had predetermined ceilings at all levels meant that whatever was to be included should be within the available budget. Therefore, anything in excess of the ceiling was left out of the action plan. At district and health center levels, it was noted that some of the items submitted by the communities were of low priority and therefore were overtaken by other prioritized matters.

In contrast, the community gave reasons which mainly blamed the health center and the DHO of neglecting the suggestions from the community. Community groups complained that health center staff tended to give priority to their own needs, thereby ignoring community suggestions. The limited participation and lack of communication with community groups seemed to fuel such suspicion.

Box 7:

“Well as you may know we have so many communities which need our attention but the resources are finite so automatically some will have to be eliminated, but then to avoid that, we ensure that health centers stick to the ceilings and planning figures . If they do that then very few activities will be left out,”
District Medical Officer

“Another reason could be that even after submitting community needs, the people at the health center writing the final action plan may not pay attention. This means that such suggestions will not be found in the action plan and the paper could be lost,” CHW Luangwa

3.3.4 Challenges in the planning process

Challenges in the planning process and suggestions of how to overcome these are summarised in Table 4 by level of health care. There were common challenges and those specific to particular levels of administration. Some common challenges included limited funding for the planning process, limited time to conduct extensive consultations with key stakeholders and lack or high turnover of trained human resources. It was a general concern that funds allocated to the planning process were limited at all levels thereby making it difficult to plan properly. The planning process required time for consultation at various levels and this usually required both funding and time especially when engaging with community members. The study noted that time allocated for health centers to consult with their community was limited and no specific funding was available to help health centers and community groups to engage with the community members in the planning process. Another challenge related to lack of trained health workers and the high turnover of health workers who were familiar with the planning process. The implication was that health centers without trained health workers were unlikely to plan properly for their activities. Some of the challenges at community level were related to lack of involvement in the planning process and lack of incentives to motivate community volunteers.

Box 8:

“I think the competence levels are low in many health centers. You know planning is technical so we need trained people. With the high turnover rate in rural areas, it is a very big challenge,” District Medical Officer

“I think the time period for the planning process is too short. As you can see, we are coming from the launch and after that, they expect us to go and call community representatives to discuss the proposals and then they have to go back and discuss these with the community members. You find that the period is just too short and at times we end up planning on behalf of the community or referring to plans from the previous year,”
Health center manager, Mbala

“Concerning community involvement, it’s difficult to see what they are doing because of shortage of staff. At the moment we don’t have an Environmental Health Technician so community meetings are not supervised. Without any supervision maybe such plans could be written by two or three people. We can’t tell if most of the people in the community are involved,” Health center manager, Chiengi

“The other challenge we face is that we do not have any resources and transportation. If we could have some money at least if each zone could have two bicycles, we could reach the faraway places,” NHC member, Chiengi

“What I have seen is that NHC used to work well when there was motivation in terms of money and other resources. Now that there is no motivation to work, people began to stop. When you call for meetings, they don’t come,” NHC member Kalomo

Table 4: Challenges in the Planning Process

Level	Challenges	Suggested solutions
District level	<ol style="list-style-type: none"> 1. Limited funds and resources 2. Limited time given to planning 3. Lack of reliable data from HMIS to inform planning 4. Lack of qualified human resources to do planning properly 5. Lack of transport 6. High staff turn over 7. Absence of planning orientation workshop 8. Poor community participation 	<ol style="list-style-type: none"> 1. Improve funding allocation for planning at levels 2. Give enough time for planning to allow for extensive consultation 3. Improve data quality at health center and community level 4. Recruit more qualified health workers 5. Provide better rural transport 6. Ensure staff retention for rural health workers 7. Provide time and resources for planning orientation 8. Provide incentives and training to community volunteers
Health center level	<ol style="list-style-type: none"> 1. Limited time given for planning 2. Poor staffing levels at rural health centers 3. Work overload at health center 4. Bad staff attitude towards planning 5. Lack of transport 6. Poor communication and cooperation between health center and community groups 	<ol style="list-style-type: none"> 1. Give enough time for planning 2. Recruit more health workers 3. Consider task shifting 4. Improve motivation and training for health workers 5. Provide bicycles and motorcycles for outreach 6. Encourage health center and community groups to work together 7. Provide training to community groups on planning 8. Ensure that new NHC members get oriented when they come into office
Community level	<ol style="list-style-type: none"> 1. Poor implementation of planned activities causing mistrust in the community 2. Lack of trained community volunteers in planning 3. High turnover of NHC members 4. Irregular meetings between health center and community representatives 5. Lack of incentives and motivation for community groups (volunteers) 6. Lack of stationery for writing (paper and pens) 7. Limited time given for engaging community groups in planning 8. Limited knowledge in planning, e.g., how to make an action plan 9. Lack of space to hold meetings 10. Health center action plan not shared with community groups 11. Lack of technical support in planning 12. Long distances between communities 13. Community groups not engaged in the planning process by health center 	<ol style="list-style-type: none"> 1. Improve funding to ensure that planned activities are actually implemented 2. Facilitate holding of regular meetings between health center and community groups 3. Provide incentives and motivation for volunteers 4. Provide stationery for community groups 5. Provide enough time for consultation during planning at community level 6. Provide training on how to make action plans 7. Ensure HCAC and other community groups have meeting rooms even when health center is busy 8. Encourage health center to share action plans with community groups 9. Provide technical and material support to community groups 10. Provide bicycles or motorcycle to targeted community groups 11. Ensure full participation of all community groups in the planning process

3.3.5 Challenges in working together in the planning process

Delivery of quality health services at community level requires that all key players work together. This ensures that there is a common vision and avoids the danger of duplication of work and unhealthy competition between various actors. One of the aims of the community mapping study was to establish the extent to which various interest groups worked together and to find out what challenges and opportunities existed. This was done at two levels. First, challenges that existed between the health center and community groups working together were identified and second, the challenges that existed between community groups working together were identified. Finally we had to establish what opportunities existed for these different groups to work together in delivering health services.

At health center level the main challenges faced in working with community groups were: limited resources to coordinate and arrange meetings with community groups, unfavorable relationships between the health centers and some community groups, and unclear roles and rules of engagement between health centers and community groups. In some health centers there appeared to be a poor relationship between the health center and some community groups especially with some NHC members who in some cases acted as supervisors to health center staff. This was made worse by lack of documentation of roles to be played by the community groups. This meant that stronger partners tended to dictate what needed to be done thereby causing frustration for weaker partners.

At community level the major challenges in working with the health center related to lack of incentives and motivation from the health center despite helping with various tasks at both community and health center levels. Most community volunteers felt abused and unappreciated by health center staff. Another challenge noted was the failure by health center staff to keep scheduled appointments. This demoralized community group members who travelled long distances only to find that meetings were cancelled. This was attributed to the health center staff being too busy with patients or simply a lack of interest by some health center staff. In some places it was reported that the health center seemed to favor some groups for example CHWs and NHCs compared to other community groups such as the Malaria Agents, Traditional Birth Attendants, and Community Based Distributors among others.

Box 9:

“...as much as we would have wanted community members to be with us as we do the health center plan and consolidation, ...due to limited funds we would not call each and every member to be present, but we could only call them maybe after the plan has come out. Then we show how the health center committee planned, but we would not call all of them,” Health center manager, Luangwa

“What I know is that the NHC is the main body of the community groups, but you find that the health center workers have interest in working with other people who are not NHC members. So you find that when they pick a person to work on other groups for example SMAG, that person will not report to the NHC,” NHC member, Chiengi

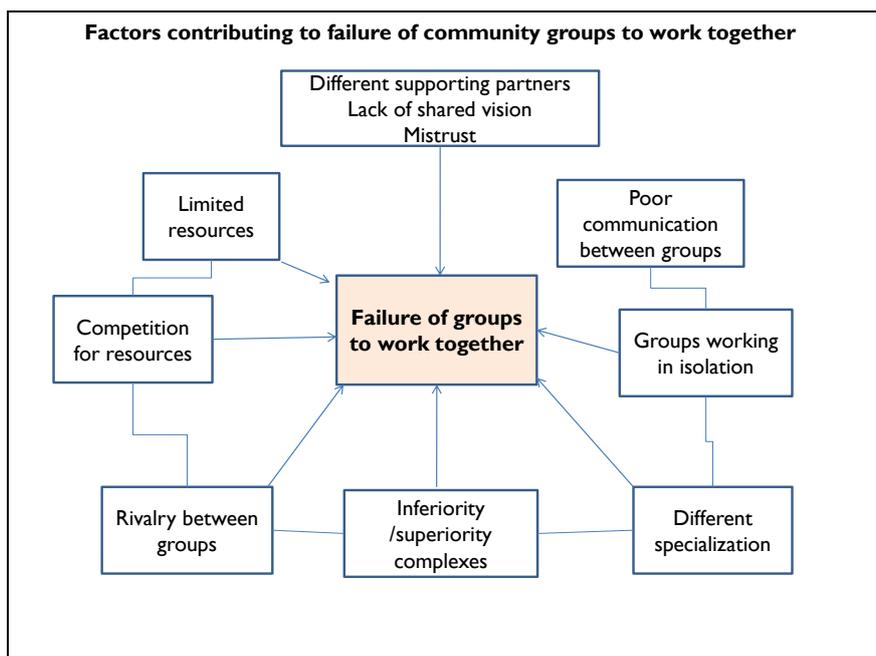


Figure 3: Factors contributing to failure of community groups to work together

Figure 3 shows factors that contributed to failure by community groups to work together. These could be summarized into three major categories: 1) lack of common vision, 2) unfairness in sharing limited resources, and 3) poor communication between groups perpetuated by supporting partners.

The study noted that different community groups were supported by different partners working in particular districts. The different community groups had no common vision and focused only on what they had been trained to do (specialization).

Resources available to community groups seemed to depend on the supporting partner. This resulted in some community groups having access to more resources compared to others. For example in Luangwa, some CHWs supported by CIDRZ received some allowances and were motivated with mobile phones for data collection while other groups had no such support. This was seen as unfair and said to have contributed to rivalry between groups leading to poor relationships and failure to work together. In some cases certain community groups received more training compared to others. This was used as a demonstration of superiority or inferiority with those receiving more training feeling more superior to those who received less training.

Lastly, it was noted that usually there were no common meetings or training for different community groups. The groups had no platform for sharing what they were doing with each other so that they could identify areas of duplication, complementary work, and could create some strong information gaps of what the different community groups are using in their respective communities. The presence of different supporting partners with different interests appeared to further re-enforce the isolation between groups.

Box 10:

“Well because these people are community health workers and TBAs, their training was a bit longer. For NHC, it would take just two weeks; then for the CHW, it would take a month. So they feel superior because they also have certificates. They have that mentality of saying that the NHC is nothing to me,” NHC member, Chifunsa

The health care workers and the community groups were asked to provide suggestions on how the existing challenges in working together could be addressed. At the health center level, what came out were the needs for fairness in access to resources by community groups, providing training on leadership to community groups and provision of incentives and other motivation.

Prominent suggestions –for the community was provision of clear guidelines and roles for community groups and providing common training for all community groups. In relation to partners working in the districts, it was suggested that they support community groups working together by adopting uniform system wide approaches.

3.4 The Funding Process and Access to Resources

It is essential that community actors receive funding to support their core activities. In most cases provision of such financing and resources cannot work without accompanying it with technical support for effective financial management. Capacity strengthening for resource mobilization, budgeting, proposal writing, accounting and processes for remuneration are some of the areas where technical support is mostly needed. One critical determinant of efficient use of resources is how the various actors in the health sector access the available resources. This is even more important at community level where resources may not reach targeted beneficiaries due to bureaucracy or simply abuse of resources at higher levels of the health system. The community mapping study explored how finances and other resources were accessed from the DHO to the final beneficiaries at community level and what channels were used to communicate approved activities to the community. In an ideal scenario, the DHO is expected to receive resources on behalf of the community as approved during the planning stage from MOH and partners. Each health center receives a certain allocation according to predetermined ceilings. The imprest is given upon proper retirement of previous imprests received. The health center is expected to sit with the HCAC to decide how the money and other resources are to be allocated with a predetermined 10% towards community activities as per MOH recommendations. At community level the NHCs and other groups are expected to receive resources on behalf of the community and distribute them according to the planned activities and giving feedback on how the resources were distributed and used. Similarly when activities are approved at district level, they are communicated to the health center and in turn the health center to the community via HCAC and NHCs.

The findings are summarized in Figure 4 below. It was noted that the DHO accessed resources from MOH and some partners as expected. However, it was revealed that some of the partners worked directly with community groups bypassing both the DHO and health center. This was noted in Lufwanyama and Luangwa where some partners supported some community groups directly. The district usually provided resources in form of a cash imprest due to the fact that health centers had no bank accounts. The health center retired the previous imprest before they could receive the new imprest. The recipient signed for the resources received and was entrusted to take this to the health center.

At health center level the findings indicated that very few health centers had formal meetings with HCAC or NHCs to discuss how the received imprest and resources were to be allocated. In the majority of cases the health center staff decided on their own and only informed the community groups to come and collect what was bought for them. *None of the community groups had ever received cash from their health centers.* They only received resources in-kind because the health worker do not trust the community groups with or account for cash if it were given to them, an assertion refuted by most community groups. It was unclear how the 10% allocated to community activities was used. The findings point to the fact that some of the community resources were actually used by health center staff, for example as allowances or fuel rather than on actual activities in the communities.

The channel of communication from district to health center was mainly through sharing approved action plans with health centers. No formal meetings were held. At health center level approved activities were usually inconsistently communicated with many community groups becoming aware only when they came to

the health center for other activities or at the time of implementing activities. Sometimes meetings were held to share approved activities in a few places noted in Zambezi though this was not consistently done.

At community level there wasn't much formal communication of approved activities. In many places the community became aware of the activities at the time of implementation. Few community groups mentioned having feedback meetings with traditional/community leaders and community members to share the approved activity usually for big projects activity such as installation of a new community bore hole.

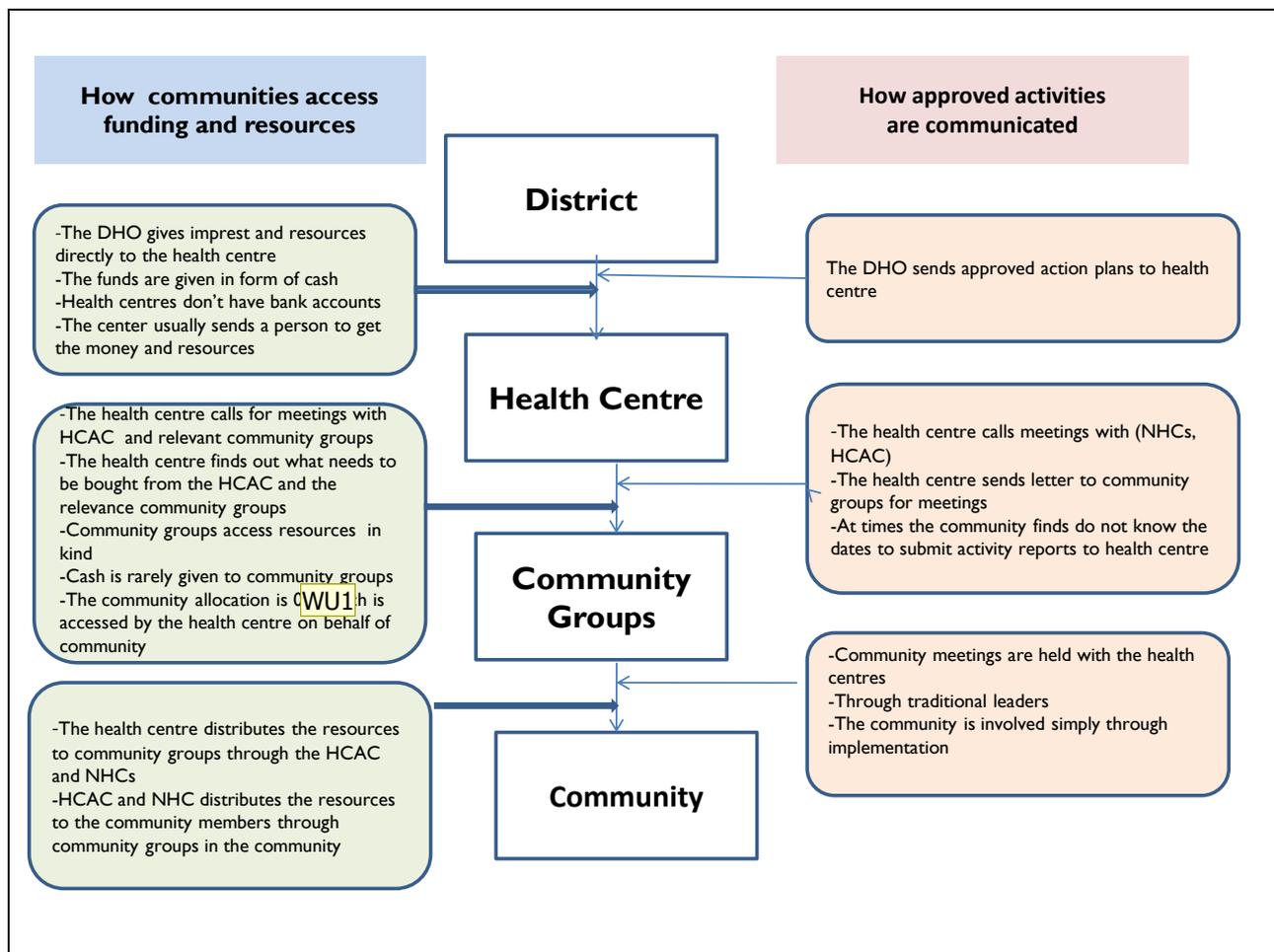


Figure 4: Access to funds and resources and how approved activities are communicated to community groups

3.5 Accountability Systems for Available Resources

Most health workers from the facilities tried to justify the presence of accountability systems for funds and resources. This could not be backed by concrete examples. Generally, there were no clear plans at either the health centers or at the community level to ensure that resources intended for use are actually tracked to make sure they are used for the intended purpose. Various attempts to monitor the use of resources were ad hoc and inconsistent ranging from ensuring recipients of resources actually signed for them to simple verification of the items purchased, activity done, activity report by the health workers. Financial reports were also mentioned as a way of accounting for resources. However each of these had major weaknesses. For example, with signatures there was no way of verifying that those who signed were true beneficiaries. As earlier mentioned, trip reports were also mentioned as a way of accounting for resources used. But reports alone could not suffice to account for resources as they were influenced by the authors.

At the health center level accounting for imprests appeared to be the main focus of the accountability system. However, the aim appeared to be retiring funds spent in order to receive the next funding rather

than a means of management and accountability to the community. It was also difficult to verify the authenticity of the receipts used to retire funds to the districts as the retiring and collection of the imprest was usually done by the in-charge without involving community groups.

3.6 Areas of Focus: Health Service Delivery

Service availability and quality are crucial in creating demand in the community. In measuring quality, several issues must be taken into consideration including gender, equity and stigma. According to the MOH, over 75% of the disease burden is attributable to HIV/AIDS/TB, diarrheal diseases, vaccine preventable diseases of childhood, malaria, respiratory infections, maternal conditions and neonatal deaths. These are the main focus areas of service delivery for the MOH 2011 strategic plan. The community mapping study collected data on availability of health services and the performance of such services. In addition, the study looked at what services were crucially lacking in the communities, especially those relating to target groups such as women, children and the youth. The results showed that most health services were offered in targeted districts including HIV prevention and treatment, child/neonatal and maternal health services, malaria and TB treatment as highlighted in the MOH 2011 strategic plan. However, the major concern was the coverage and quality of services being provided. It was noted that health centers far away from the district had challenges accessing Emergency Obstetrics and Neonatal Care (EmONC). In addition, lack of trained health human resources and essential drugs hindered provision of quality health care especially in the rural health centers.

Participants were asked to rank services based on perceived or actual performance relative to other services being provided at district and health center levels. This was done in order to isolate services that need urgent attention and those that require sustaining or scaling up. Table 5 below summarizes the results. In terms of performance, HIV services were said to be doing well in most health centers. This was attributed to good partner support in this service area. In most places maternal health services were rated poorly. These included family planning and institutional delivery services.

Table 5: Performance of Various Health Services Offered In the Target Districts

District	Doing well	Not doing well
Chiengi	HIV services especially ART services	Mental health services
	PMTCT services	Family planning
	ANC services	Referral services for pregnant women
	Sanitation services	
Lufwanyama	HIV services (treatment and prevention)	Laboratory services
	ANC Services	
	TB services	
	Child health services	
Nyimba	HIV services, treatment and prevention	Institutional delivery services
Kalomo	HIV services	Family planning services
	Treatment both mobile and static services	Youth targeted services
Lukulu	HIV services including ART services	Outreach services
Kapiri Mposhi	HIV services, pediatric and adult ART services	Laboratory services Curative services due to shortage of drugs
	Malaria	
Mbala	ANC services	Youth targeted health services
	HIV services	Institutional delivery services
	Malaria	
	Family planning services	
	TB services	
Luangwa	Malaria	Institutional delivery services
	HIV services (treatment and prevention)	
	ANC services	

Zambezi	Child health services	Family planning services
	HIV services	

Respondents were also asked to list services that were crucially lacking and provide reasons why they were needed in the community. Generally, services which were lacking in the majority of health centers were: nutrition, ambulance, dental and eye. Others were adolescent reproductive health services, laboratory, and sanitation. Shortage of trained health workers was frequently mentioned as affecting the quality of health services. Reasons given for the needed services are shown in Table 6. For example ambulance services were needed because of long distances when referring pregnant women with complications to the district hospital. Zambulances were recommended as an alternative to an ambulance especially in rural health centers (See Figure 5).

Figure 5 Modified Bicycle Known as Zambulance

A Zambulance is a bicycle driven ambulance with a covered platform used to bring people to the health center who cannot walk, particularly pregnant women who live far away from health centers to improve maternal, newborn and child health outcomes. With Zambulances, pregnant women can be transported for ante and postnatal checkups and other preventive services, in addition to other medical emergencies.



Table 6: Services Most Needed In the Surveyed Districts

Chiengi	Ambulance	Long distances to the referral hospitals for pregnant women
	Nutrition	High prevalence of malnutrition in the area
Lufwanyama	Nutrition	High prevalence of malnutrition in the area
	Water and sanitation	Poor sanitation
	Laboratory	Only few tests are done at local clinics
	Mortuary	Long distance to the district hospital in some areas
	More trained health workers	Shortage of qualified health workers
Nyimba	Ambulance	Long distance to referral centers
	More trained health workers	Acute shortage of human resources
Kalomo	Nutrition	Malnutrition is a big problem in the community
	Youth reproductive health	High prevalence of teenage pregnancies
	Shortage of essential drugs	Irregular supply of essential
Lukulu	Nutrition	Nutrition support required for children and people living with HIV/AIDS
	Malaria prevention	High prevalence of malaria in the area
	Water and sanitation	Poor water and sanitation in the community
Kapiri Mposhi	Dental	No help is available for people with dental problems
	Eye	No help for those with eye problems at health centers
	Youth reproductive health	More young people with unplanned pregnancies
	Ambulance	Poor referral services especially for pregnant women
Mbala	Blood transfusion	Only done at district hospital
	Ambulance	Long distances between district and some health centers
	Shortage of essential drugs	Anti-rabies vaccines never available
Luangwa	Ambulance	Long distances to refer patients to Katondwe Mission Hospital
	Youth reproductive	High prevalence of teenage pregnancies in the area
Zambezi	Nutrition	Need to support OVC s and people living with HIV/AIDS
	Ambulance	Poor referral services from health centers to the district

3.7 Behavior Change and Communication

BCC is the strategic use of communication to promote positive health outcomes, based on proven theories and models of behavior change. BCC employs a systematic process beginning with formative research and behavior analysis, followed by communication planning, implementation, and monitoring and evaluation. BCC is also an essential tool for social mobilization in community health programs.

For BCC to be effective, training and capacity building in design, implementation and evaluation are critical. It is vital that BCC materials and activities are developed for audiences with specific health and social needs. The success of BCC will largely depend on the extent to which community members are engaged in planning and developing relevant BCC for specific target groups in the community.

The community mapping study collected information on various components of BCC including types of BCC, area of distribution, area of focus, language used and whether community groups were/are engaged in BCC activities.

Table 7 gives a summary of the BCC materials and activities stratified by district.

It was noted that the commonly available BCC materials included brochures, booklets and leaflets. These were mainly supplied by partners and the DHO. No district had a health promotion coordinator except for Kalomo district that recently received someone to fill this post.

The supplied materials from partners focused on the areas of their interest. Most partners were working in the area of HIV/AIDS and so it was not surprising that most of the materials were focused on HIV/AIDS. The messages were mainly on prevention of HIV including voluntary counseling and testing (VCT) and condom use.

When it came to target groups, most materials were targeted at both men and women. Few magazines were targeted at adolescent reproductive health, for example the Kwatu magazine in Chiengi and Mbala, while in Lukulu district it was reported that some of the BCC materials had a child health focus. However, these were mainly available during national campaigns like child health week. Most of the materials were displayed at the health centers. Schools were mentioned in Lukulu and Zambezi districts as places where BCC materials were distributed. None of the participating community groups distributed any BCC materials except for a few irregular supplies during national campaigns like child health week, TB day and AIDS day. Almost all BCC materials were in English language.

Table 7: Behavior Change and Communication Materials, Source, Distribution, Focus Area and Language

District	Commonly available BCC materials	Sources	Places of distribution	Area of focus	Language used	Available with community groups
Chiengi	Magazines (Kwatu), Leaflets	DHO, NZP plus	Health centers	HIV and AIDS	Mostly English	No
Lufwanyama	Leaflets, brochures, posters	DHO	Health centers	HIV and AIDS, child health	Mostly English	No
Nyimba	Leaflets, posters	Provincial Health Office, DHO	Health centers	HIV and AIDS	Mostly English	No
Kalomo	Leaflets, brochures, posters	Provincial Health Office, DHO, DAPP, Society for Family Health , CIDRZ	Health centers	HIV and AIDS, family planning, TB, PMTCT	Mostly English	No
Lukulu	Magazines (Kwatu} Brochures, posters	DHO DATF	Health centers Schools	HIV and AIDS, VCT, alcohol, child health	Mostly English	No
Kapiri Mposhi	Pamphlets, posters, booklets	DHO	Health center Schools	HIV and AIDS, alcohol	Mostly English	No
Mbala	Posters, brochures, magazine (Kwatu}	DHO	Health center	HIV and AIDS, malaria, sanitation, TB	Mostly English	No
Luangwa	Brochures, booklets	IntraHealth, CIDRZ, CHAZ HCP	Health center	HIV and AIDS, malaria and child health	Mostly English	No
Zambezi	Posters, leaflets	DHO, UNICEF	Health center Schools	HIV and AIDS, VCT, malaria, sanitation	Mostly English, some in Bemba	No

3.7.1 Common behavior change communication activities

The most common BCC activities mentioned were drama and health education. Most of the drama groups were supported by partners or the DHO. It appeared that drama groups were usually paid for their activities. Some groups were local while others were called from the district when they were needed. Because of the expense involved, most health centers and community groups could not afford to engage these drama groups except during special national campaigns when partners and the DHO paid to hire the drama groups.

Health education was the most common form of BCC activity carried out by NHCs, CHWs, SMAGS, lay counselors, TB supporters and other community groups. The NHCs were covering environmental health issues while other groups were more specialized and focused on specific topics such as TB, maternal health and/or HIV/AIDS. This was done routinely or during special national campaign days. Most of the health education was done without any visual aids as these were generally not available. The education was done either through visits to individual households or group meetings especially during special national campaigns.

Box 11:

“There is a challenge with the drama group because they don’t want to act for free. For every job done they want an allowance,”
NHC member, Luangwa

“We don’t have drums or anything, so we just sensitize the community orally,” NHC member Lukulu

One form of social mobilization which was lacking but highly recommended was use of video shows either static or mobile. This was seen as appealing for young people in the community. However, availability of power could be a limitation in some communities. In such places working with partners like the Zambia News and information Services (ZANIS) could provide a way forward for places without power. Most respondents would like to see BCC materials and activities done in local languages

Box 12:

“In the communities some people can’t read English. It could be better if when the materials come, they are in Tonga as well, so that those NHCs in other zones distribute both Tonga and English,” NHC member Kalomo

“I would like to see programs, like we used to hear in the past where NHCs members used to come on the radio, so whoever had a radio in the village could use it so that other people could listen to such programs. A lot of people used to follow such programs and they liked them,” and NHC member, Kalomo

In almost all the districts visited the most required BCC materials were brochures and posters. Others were leaflets, pamphlets and fliers. Most of the respondents wanted materials to cover more topics than simply HIV. The most required topics other than HIV were materials covering STIs, maternal/neonatal/ child health, adolescent reproductive health and general sanitation. The languages of the required material were dependent on the common languages spoken in the target districts (See Table 8 for details). Radio programs using community groups were highly recommended especially if presented by local people.

Table 8: BCC Materials Needed and Language

District	Types of materials	BCC activities needed	Content	Language
Chiengi	<ul style="list-style-type: none"> • Brochures • Booklets • Fliers • Posters 	Radio, video shows, drama groups	<ul style="list-style-type: none"> • Malaria • HIV/AIDS • Antenatal • TB • Nutrition • Family planning • Adolescent reproductive health • Diarrhea • Materials on cancer 	Bemba and English
Lufwanyama	<ul style="list-style-type: none"> • Pictures • Posters • Brochures 	Radio, video shows, drama groups	<ul style="list-style-type: none"> • HIV/AIDS • Malaria • Tuberculosis 	Bemba, Lamba or English
Nyimba	<ul style="list-style-type: none"> • Posters • Brochures 	Youth friendly corner Radio, Video shows	<ul style="list-style-type: none"> • Adolescent reproductive health • HIV/AIDS 	Nyanja and English
Kalomo	<ul style="list-style-type: none"> • Posters • Brochures 	Radio Video shows Drama groups	<ul style="list-style-type: none"> • Malaria prevention • Tuberculosis • HIV and PMTCT, • Cancers 	English and Tonga
Lukulu	<ul style="list-style-type: none"> • Posters • Brochures 	Radio Video shows Drama groups	<ul style="list-style-type: none"> • HIV/AIDS, TB, and malaria • Diarrhea • measles • Sexually transmitted diseases(STI) 	Lozi, Luvale and English
Kapiri Mposhi	<ul style="list-style-type: none"> • Brochures • Posters • Leaflets 	Radio Video shows Drama groups	<ul style="list-style-type: none"> • Malaria • HIV/AIDS 	Bemba and English
Mbala	<ul style="list-style-type: none"> • Brochures • Posters • Leaflets 	Radio Video shows Drama groups	<ul style="list-style-type: none"> • Child health • Family planning • Adolescent reproductive health • Sanitation • Malaria prevention, • HIV/AIDS 	Mambwe, Bemba and English
Luangwa	<ul style="list-style-type: none"> • Brochures • Posters • Leaflets 	Radio Video shows Drama groups	<ul style="list-style-type: none"> • Malaria • HIV/AIDS • STIs • Adolescent reproductive health 	Nyanja and English
Zambezi	<ul style="list-style-type: none"> • Brochures • Posters • Leaflets 	Radio Video shows Drama groups	<ul style="list-style-type: none"> • Antenatal • HIV and AIDS • Malaria • Polio • Measles • Immunization • Water and sanitation 	Luvale, Lunda, Bemba and English

3.7.2 Gaps and challenges in behavior change communication

Data were collected on the major gaps and challenges with BCC at various levels. The challenges could be categorized by level of health care. At the district level there were three major gaps: 1) lack of a

Box 13:

“Yes, as it is now, of course materials may come. Radio programs may be supported but we need people on the ground to coordinate.... and then they an work with the health center and the district,” DMO Kalomo

“For us to change people’s behaviors here, it is better that some trainers come here to train us so that we can also train others to sensitize the community on behaviour change communication.” NHC member, Lukulu

BCC focal person, 2) lack of coordination in the supply and distribution of BCC materials, and 3) lack of motivation for community groups. It was observed that BCC activities were uncoordinated with partners working parallel to the DHO. In some cases the district was unaware of what BCC materials and activities were being carried out by partners in the district. This was attributed to lack of a focal person in-charge of BCC at district level resulting in poor coordination.

At health center level the gaps included irregular supply of BCC materials, lack of funds to conduct BCC activities and motivate community volunteers.

At community level the gaps and challenges were similar to those at health center level. In addition, lack of training and long distances in rural areas were some of the challenges, particularly at community level.

3.7.3 Challenges integrating, monitoring and evaluating behavior change communication activities

Generally there was no challenge in integrating BCC activities in action plans at health center level. The main challenges were funding and subsequent implementation of the proposed activities. At community level, lack of training in making action plans limited the extent to which they could advocate for integration of BCC as the majority of the community groups never had their own action plans.

The study also revealed poor coordination, monitoring and evaluation of BCC activities at all levels in the surveyed districts. The supply of BCC materials was irregular, and materials were mostly available during national health campaign days.

The process of identifying the type of BCC needed was very weak. The community groups were rarely consulted and the health center didn't seem to play a role in identification of BCC materials required in their catchment areas. The BCC identification appeared to emanate from central level through specific directorates at the MOH in Lusaka.

3.8 Reporting Systems at All Levels

Local health information can be a powerful vehicle for improving the health of a community. It can highlight both the existence of problems and opportunities for improvement. It can also guide local action in support of policy changes and improve programs' effectiveness. Unfortunately most of the health information collected tends to ignore information generated at community level. Ignoring such community generated data gives a false picture of what really is going on at community level. One key element in the community health system strengthening is supporting community-based data collection by community volunteers. This calls for provision of data collection tools and systems for reporting such information so that it can be provided to and used by the health center for submission to the national health information system. Existence of such tools and mechanisms is very crucial, hence this study collected information on the availability of tools for collecting community level health information and how there data were reported to the health center.

The findings showed that almost all community groups had no data collection tools except for a few groups supported by partners. These included CHWs supported by CIDRZ in Luangwa, World Vision in Kalomo, and TBAs supported by Child Fund in Nyimba. While some of the community groups that collected community level data submitted there to the health center, others only submitted the information to their supporting partner. Information was submitted to the health center quarterly or monthly depending on what was practical. The major challenges in collecting information were long distances to cover when collecting community data and lack of stationery (pens and papers) or forms to use (See Table 9).

Table 9: Availability of Data Collection Tools at Community Level

District	Level	Availability of tools	Type of tools	Who provides
Chiengi	NHCs	None		
	CHWs	None		
	Other groups	None		
Lufwanyama	NHCs	None		
	CHWs	None		
	Other groups	None		
Nyimba	NHCs	None		
	CHWs	None		
	Other groups (TBAs)	Yes	Paper forms	Child Fund
Kalomo	NHCs	None		
	CHWs	Some CHWs at Chifunsa Health Center	Paper	World Vision
	Other groups	None		
Lukulu	NHCs	None		
	CHWs	None		
	Other groups	None		
Kapiri Mposhi	NHCs	None		
	CHWs	None		
	Other groups	None		
Mbala	NHCs	None		
	CHWs	None		
	Other groups	None		
Luangwa	NHCs	None		
	CHWs	Some CHWs at Bhoma Health Center	Paper and electronic forms	CIDRZ as part of health systems strengthening
	Other groups	None		
Zambezi	NHCs	None		
	CHWs	None		
	Other groups	None		

3.9 Influential Community Leaders

Traditional and local leaders are influential in many African countries especially in rural communities. They act as "custodians" of African culture and play a key role in advocating for community health initiatives. It is the policy of the MOH to work with local leaders to improve community health in Zambia. Acting as gate keepers and opinion leaders, their support is indispensable when introducing new programs in the community. The community mapping study explored the availability of influential leaders in target districts and to establish their current roles and support health services

The most influential and active local leaders were traditional leaders. These included village headmen and some local chiefs. The chiefs in Kalomo district were said to be very active in supporting health services. They provided both material and financial support to health activities in the area. Other activities done by traditional leaders were helping in organizing the community for health activities. They also acted as a catalyst in integrating new health programs when introduced in their areas. Religious leaders supported health activities through announcing programs in the churches. In some places like Lukulu, they were also involved in health infrastructure development and training of local community groups. Political leaders were less active in supporting health services.

It was noted that most of the influential leaders were men. Very few women were mentioned among influential community leaders, for example, in Lukulu, there was one Catholic sister who was said to be very influential supporting HBC and health infrastructure development (See Annex 8.2 for details).

4 DISCUSSION

The study has revealed major opportunities and challenges in the study districts where ZISSP will be implementing activities. While the study collected data from nine out of the 27 intervention districts, the similarities in terms of rural residence and associated challenges means that some of the findings could apply to all ZISSP districts with similar settings.

4.1 Community Groups and Partners in the Target Districts

In most of the health centers visited, it was evident that NHCs existed. They were well recognized and appreciated in many places. In fact they were the most active group among the community groups. Their role seemed more cross cutting compared to other groups who were more specialized like the TBAs and SMAGS. Other notable groups were CHWs and TBAs who worked mainly in the community though they helped at the health center from time to time when needed. It is important to note that the level of involvement of the community groups in service delivery differed greatly with some health centers taking full advantage of the presence of the community groups while other health centers rarely involved community groups. In some cases noted in Lukulu and Kalomo districts, some NHCs were not active though they used to be very active in the past, especially when the Central Board of Health was in existence. This reference to the time of Central Board of Health was very clear in Chiengi, Kalomo and Lukulu districts. It appeared that the Central Board of Health had a more proactive approach to engaging community groups in the provision of health services.

The presence of co-operating partners was noted in all the districts visited with some districts having more partners than others. The most common partners were CIDRZ, ZPCT II, World Vision and CHAZ. Others operating in few districts were Boston University in Kalomo, Child Fund in Luangwa and Lufwanyama, and Integrated Neonatal and Child Health (LINCHPIN) in Lufwanyama.

The most interesting thing to note was that apart from World Vision and Child Fund, most of the partners had a focus on HIV/AIDS. This could be attributed to the fact that HIV/AIDS is a major public health problem in Zambia and so much funding and attention have been channeled towards it. However, with the current high disease burden in Zambia, system wide approaches are recommended rather than a narrow disease-specific focus.

4.2 Gender Integration

Gender inequalities can affect access to health care. The study revealed lower women representation especially at community level. Gender analysis of the HCACs showed that women representation was less than 40% in most places. The fact that none of the chairpersons of the HCAC was a woman indicates the gender imbalances that existed in the study communities.

4.3 Planning Health Services: Participation and Roles

The study coincided with the time of launching the planning cycle for districts and health centers, therefore a good time to see exactly who was involved in and some of the practical challenges with the planning process. In all the districts surveyed, the findings indicated active participation of the DHO and the health centers in the planning process. The DHO and the health center staff appeared to be clear about their roles in the planning process. They were well informed about the timeline and the required inputs in the planning process and had planning manuals that acted as references for areas of focus and how to practically develop an action plan using the planning manuals from the PMO.

However, the study found that the level of the community groups' involvement in the planning process was very low. Apart from NHCs members who were represented through the HCAC during the planning process in a few health centers, most of the community groups denied taking part in the planning process or

being consulted for any input.

It was generally assumed by the DHO and health center that NHCs involved the community and other groups in coming up with suggestions for action plans. However, this rarely happens as noted from challenges that were faced by community groups. *The major challenge noted across all levels was the limited time given between the launch and submission of action plans.* There has been a shift by the Zambian government in the budgeting cycle in recent years with the financial year starting in January instead of March. This has meant that the districts and health centers have to submit their action plans three months earlier than before. However, the timing of the launch has remained the same as before, thereby giving little time for community engagement and consultation. Most of the community groups complained that they were hurried in submitting their plans and ended up submitting incomplete plans or plans from the previous year.

Other challenges in the planning process at district level included poor quality data to inform planning and a shortage of qualified manpower to help with the planning process. At community level some of the challenges in the planning process included lack of training and orientation in planning and lack of stationery to use in collecting information from the community. There was a feeling among community groups that the planning process was a mere formality as most of the issues included were rarely implemented. This has been a great source of frustration for both community groups and health center and has affected the morale for participating in the planning process among the community groups. It is unclear who is to blame for failure to implement planned activities because the health worker consistently talks of the inadequacy of the funds received from the PMO while the community puts the blame on the health care workers as not prioritizing the community activities.

4.4 Community Capacity Building

The study wanted to establish the support which community groups received from the health center and partners. While it is a mandate of the health center to provide capacity building for community groups and provide oversight, it appeared that limited resources had made it difficult for the health centers to provide meaningful capacity building activities for community groups. Apart from the initial orientation of 3 to 4 days given to community groups, most have not been trained. However, the orientations were followed by some meetings to consolidate some practical lessons. In addition, there is high turnover in the composition of these groups for example the NHCs which change every two to three years. Therefore, most current members have not received any form of orientation or training. The deficiency in capacity building was even more evident in the process of planning and BCC.

Though some partners had tried to provide capacity building activities for community groups, they usually did this for groups that were related to their interests and not according to health priorities in the community. One example of a partner working in Luangwa training CHWs was CIDRZ. These CHWs were given formal training and provided with a small allowance. They appeared to be well motivated and happy to help at the health center. Another partner was LINCHPIN in Lufwanyama. This partner trained NHCs and other groups to make action plans and provided material and technical support.

4.5 Challenges Working Together: Community Groups

Despite the high number of community groups found in all the study districts, they rarely worked together. They appeared to be working in isolation and lacking a common vision. This was made worse by some partners who tended to select special groups while leaving others unaware of the work done by such groups. There appeared to be unhealthy competition and complexities that fuelled rivalry rather than unity among the community groups. While competition should be encouraged between different community groups, care must be exercised to ensure that this competition does not become a source of conflict. The case of CHWs and NHC members provided insight of the extent of rivalry between some community groups. The study found that some NHC members see themselves as superior to CHWs and even superior than the health center staff. This has been made worse by lack of clear roles and a job description for community groups. This has led to poor relationships in some health centers among the community groups

and is a major source of disunity and conflict among community groups. The main contention was to do with who was supposed to supervise whom and why. This finding points to the need to define roles and give clear job responsibilities for all community groups including structures of operations. .

4.6 Behavior Change and Communication

The importance of developing BCC materials cannot be overemphasized. This can be evidenced by a number materials developed by the MOH and its implementing partner. The most common available BCC materials were the brochures, booklets and leaflets in all the study districts which were mainly supplied by the MOH to the DMO through to the health centres. However, the materials supplied by the partners focus on their area interest which is HIV/AIDS and so it was not surprising that most of the BCC materials were mainly on HIV/ AIDS.

Despite some BCC materials being available, generally the supply of these materials is very irregular and very uncoordinated in most cases. The structure of the MOH has a health promotion focal point person at provincial which can be strengthened to ensure regular distribution of the BCC material to the DHO and health centres as the position of the district health promotion is still under consideration because none of the study districts had a district health promotion coordinator except for Kalomo which recently received someone to fill this post.

However, what should also be noted is that BCC is not that effective and for it to be effective, some training and capacity building should be done in the designing and implementation with the involvement of the community. Some BCC materials were found not to fit the target audience largely because the materials are developed without the involvement of the community who are the target audience.

The majority if not all the available BBC materials were in language which rather another challenge if you look at the target audience. This gap requires urgent attention. Use of video and radio was less pronounced though the community groups felt these would be well accepted by the community.

Most of the materials were displayed at the health centers and some few strategic places such the markets, churches and some good public places. Schools were also mentioned in Lukulu and Zambezi districts as some of the places where BCC materials were displayed. Most worrying was the fact that the community groups are not used as routine agents in the distribution of BCC materials to the community members. However, the community groups were only used when advancing a national health campaigns which are very ad hoc. Most BCC activities tended to be organized around national campaign days. They involved mainly drama and educational meetings in the communities.

4.7 Gaps in Provision of Health Services

Most basic health services were available in the study districts. However, the quality and coverage of the services was a major source of concern. Some services were totally absent or working below the minimum acceptable standards in most places, such as nutrition support for children and adults, dental, eye care, adolescent reproductive health and ambulance transport. There was also a concern about the availability of EmONC services especially in communities that were far away from district hospitals. In Lufwanyama one community used a Zambulance which is an adaption of an ambulance for transporting pregnant women to health centers. This initiative was supported by the community and supporting partners by buying bicycles and provision of training.

5 CONCLUSION

The study achieved its objective of mapping existing community resources in selected districts by highlighting opportunities and challenges at all levels of service delivery. It revealed the current state, potential and capacity for health service delivery and highlighted major challenges hindering the potential to deliver quality health care.

The main findings indicated that several structures existed at community level which included different community groups, NGOs, and other implementing partners in health service delivery. The most common community groups across all study sites were Neighbourhood Health Committees (NHCs), Community Health Workers (CHWs) and Traditional Birth Attendants (TBAs). However, other community groups also existed such as the Malaria Control Agents, Lay Counsellors, Home Based Care, TB Treatment Supporters, Peer Educators, Adherence Supporters, Growth Monitoring Promoters, and SMAGs though not to a large extent. Generally the NHCs, CHWs and TBAs were found to be the most active community groups based on report submission and their roles in the community. On one hand, the study noted the failure by community group to work together in delivering health services. On the other hand, the study also established that there was potential for synergy among various community groups and partners because some community groups and partners had similar roles despite working in isolation.

Partners were largely dependent on the district visited though some partners appeared to be in more than one district. The study noted that most of the partners worked in the area of HIV/AIDS supporting treatment and prevention interventions.

The study further showed that most essential health services were offered in targeted districts. However, the coverage and quality of some services was very poor such as nutrition services for children and adults, dental, eye services, adolescent reproductive health services and ambulance services. Availability of Emergency Obstetric and Neonatal Care services especially in communities that were far away from district hospitals was limited. In addition, lack of trained health human resources and essential drugs hindered provision of quality health care especially in rural health centres.

Participation of community groups across all activities was very low. This was evident in the areas of planning and conducting BCC where community groups were rarely involved. Generally, low funding, limited time, and lack of training were the major challenges in the planning process at community levels.

In all the study districts, the commonly used BCC materials were brochures, booklets and leaflets. These were mainly supplied by partners and the District Health Office. The supply of BCC was irregular and uncoordinated and was mainly focused on HIV prevention. The major weakness about the available BCC material was that most of the materials were in English with very few BCC materials in local languages.

The study has highlighted areas of urgent attention and provided general and specific recommendations as a way forward.

6 RECOMMENDATIONS

6.1 General Recommendations:

- 1) Many community groups and partners existed in the study districts. However, coordination among the actors was very poor.

The study recommends building coordination capacity at the DHO, facility and community level to coordinate the activities of various stakeholders and partners working in the districts.

- 2) Generally, the planning process was being hampered by limited funding and time to allow for adequate planning at all levels

Because of the limited funding, there is need for adequate training so that priority activities are planned for and ensure that enough time is allocated for community to participation in the planning process.

- 3) Though many community groups were willing to contribute to health service provision, they generally lacked capacity and materials to carry out their work. Also it was established that the community groups do not have clearly defined roles how to work with the health centres and the community members.

Priority should be given to building capacity for community groups and by providing them with basic materials to carry out their work effectively. There is need to have clearly defined roles and responsibilities for the community groups.

- 4) The study noted that representation of women in leadership positions at community level was very low.

There is a need to consider gender mainstreaming and integration in leadership roles especially at community level.

- 5) Many community volunteers were discouraged and working below capacity. This was attributed to lack of incentives and resources to carry out their work.

The MOH and its cooperating partners should consider various options to motivate community volunteers including providing training, certification, identity cards and small allowances depending on feasibility and availability of resources.

- 6) Though most health services were available in many communities, the coverage and quality were poor for many of the services. This was attributed to among other things, lack of trained health human resources.

The MOH and its cooperating partners should explore and consider how best to provide incentives for recruitment and retention of trained health workers especially in rural areas.

6.2 Specific Recommendations:

6.2.1 Planning Process

6.2.1.1 Recommendation to MOH

1. Provide necessary training to enable prioritization of activities during planning especially at community level. .
2. Improve and strengthen the funding system to ensure that what is supposed to go to the community level gets there according to their approved plans.
3. Give sufficient time for planning to allow for sufficient consultation
4. Improve the quality of HMIS data at health center and community level
5. The initiative of the Zambia Health Workers Retention Scheme (ZHWRs) is a very good idea, which needs further government support because its not sustainable if left to the donors.
6. Provide incentives (certificates, T-shirts, Uniforms, bicycles etc) to community volunteers
7. Provide training to community volunteers
8. Define uniform, standard roles and responsibilities and reporting structures for community groups and how they related and link to the health center, with health centers roles and responsibilities clearly defined
9. Develop clear roles and job description for community groups (job aids).

6.2.1.2 Recommendation to cooperating partners

1. Provide timely training to community groups about the planning process
2. Facilitate full participation of all community groups in the planning process
3. Facilitate working together of all community groups in the DHO and/or health center catchment area
4. Provide the NHC members with orientation every after 2 years for any new updates
5. Facilitate holding of regular meetings between health center and community groups
6. Provide incentives and motivation for volunteers were feasible (e.g., *identity cards, certification after training, food during meetings and small allowances*)
7. Provide stationery for community groups to use when doing community data collection
8. Provide enough time for consultation during planning at community level
9. Provide training on how to make action plans
10. Ensure HCAC and other community groups have a meeting room even when the health center is busy
11. There is need to encourage the health centers to share the approved action plans with community groups and also sensitize the community groups to demand for the approved action plans.
12. Provide technical support such training and material support to community groups such as bicycles, T.Shirts, etc.
13. Provide bicycles or motorcycle to targeted community groups to ease transport problems.

6.2.2 Behavior Change and Communication

6.2.2.1 Recommendation to the MOH

1. Harmonize the supply and distribution of BCC materials from central to community levels
2. Ensure regular supply of BCC materials to the facilities and ensure the materials reach the community
3. Ensure that partners work with respective DHO in ordering and distributing BCC materials

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4. Ensure that more health topics are covered rather than the current focus on HIV/AIDS which should include, family planning, malaria, child nutrition, adolescent among others health related topics.
 5. There is need to prioritize the inclusion BCC activities during the planning process and strengthening of the distribution of the BCC material from the DHOs to the Facility and through to the community level
 6. Maintain the national health campaign days like child health week, AIDS day and TB day, but ensure that BCC activities and materials are available routinely throughout the year and not just during these special national campaigns
 7. Ensure that the BCC materials are translated into respective local languages.

6.2.2.2 Recommendation to cooperating partners

1. Ensure community participation in developing relevant BCC materials
2. Facilitate adaptation of BCC materials and activities into local languages
3. Train community groups in planning for BCC in their communities
4. Facilitate the engagement of community groups in distributing BCC materials in their community
5. Facilitate regular supply and replenishing of relevant BCC materials at community level
6. Build capacity at health center and community level in conducting BCC activities and social mobilization such as drama
7. Facilitate use of community radio stations using local community groups and influential people
8. Facilitate use of videos where this is feasible especially when targeting young people.

6.2.3 Services Needed in the Communities

6.2.3.1 Recommendation to the MOH

Provide support to ensure targeted improvement in the following services that are absent or performing poorly:

1. EmONC
2. Nutrition support especially for children and people living with HIV
3. Ambulance services especially for women and children
4. Dental services
5. Eye care
6. Strengthen youth friendly services
7. Strengthening family planning services.

6.2.3.2 Recommendation to Cooperating Partners

Work with the ministry of health and the government to improve services lacking or performing poorly

1. EmONC: work with community groups especially SMAGs and TBAs to improve maternal and child health services
2. Nutrition support especially for children and people living with HIV: work with community leaders and communities in identifying agricultural activities that can act a source of income and nutrition especially for children and other vulnerable groups
3. Ambulance services especially for women and children: facilitate the acquisition of Zambulance especially for communities which are far away from health centers and district hospitals

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4. Dental services: work with local health centers and MOH to facilitate mobile or static dental services
 5. Eye care: work with local health centers and MOH to facilitate mobile or static eye services

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8 ANNEXES

8.1 Partners currently working in selected Districts

	Partners	Service provided to the local community by the partner
Chiengi	Red Cross	Child health services
	ZPCT II	HIV prevention care and treatment Training for lay counselors
	World Vision	Provision of funding to nutrition groups especially people living with HIV patients
	Luapula Foundation	Provision of OVC support and material support to people living with HIV
	Catholic Church	OVC support
	DATF	HIV coordination and supporting HIV related activities at district and community level
	Care International	Child health activities and supporting some community groups working with child health
	UNFPA	Reproductive health
	UNICEF	Child health services
	Lufwanyama	CHAZ
LINCHPIN (Boston University)		Training community groups in new born and child care
World Vision		Water and sanitation programs in the community
Catholic Church		OVC support
Society for Family Health		Mosquito net and condom distribution
Nyimba		Child Fund
	Peace Corps	Health education and training of community groups like NHCs
	Society for Family Health	Mosquito net and condom distribution
	CIDRZ	Teaching community members how to raise livestock after which they give the successful candidates some livestock to start rearing and support ART program
	World Vision	Provision of medical kits to some community groups
Kalomo	DAPP	Community hygiene and sanitation
	CIDRZ	Provision of HIV and TB services in the community including counseling and testing Antiretroviral therapy Training of human resource working in their programs
	Society For Family Health	Family planning
	University of Boston	Provision of PMTCT services Training PMTCT Provision of technical support in the health centers, Provision of logistical support to the DHO during national health days
	JICA	Provision of mobile ART services
	World Vision	Water and sanitation Nutrition support
	Pilgrim Wisley Church	Training on HBC
	Intra Health	HIV testing and Counseling
Lukulu	CIDRZ	HIV and TB services Antiretroviral therapy training of human resource working in their programs
	CRS* (Phased out)	Nutrition support HBC Provision of material and financial support for community groups
	New apostolic Church	OVC support
	Local Council	Public health services
	Barotse Royal Establishment	Supports health initiatives in the community

	DATF	HIV coordination
	Catholic Church	HBC Infrastructure development Nutrition support
Kapiri Mposhi	World Vision	Water and sanitation
	Corridors of Hope	Health education and training of lay counselors
	Care International	Nutrition support to malnourished children
Mbala	World Vision	Growth monitoring and promotion Water and sanitation
	Peace Corps	Health education
	Ministry of Agriculture	Food security
	Ministry of Education	National health events and HIV/AIDS programs
Luangwa	CIDRZ	Training of CHWs Financial and material support to community and health centers HIV treatment (ART) program
	Intra Health	Counseling and testing (mobile and static)
	Child Fund	CBD Malaria prevention Water and sanitation
	ZAMBART	Health system strengthening in collaboration with CIDRZ
	CHAZ	OVC support Malaria prevention. Rapid diagnostic tests Training to adherence supporters and other community groups ART
Zambezi	CHAZ	OVC support Malaria prevention. Training to adherence supporters and other community groups ART
	Catholic church	Infrastructure and HBC
	ZPCT II	HIV prevention care and treatment counseling and testing palliative care
	Nazarene Church	HBC and OVCs
	(CMML)	Schooling and care for OVC s
	New Apostolic Church	OVC care and support

8.2 Influential Community Leaders Supporting Health Services in the Target Districts

District	Category	Activity level	Example	Work done
Chiengi	Traditional	Active	Village Headmen	-Organize the community -Participate in community sensitization on health
	Political	Active	Ward counselors	Organize community members for health activities
	Religious leader	Not active		
	Other	Not active		
Lufwanyama	Traditional	Active	Village Headmen and chief advisers	Community sensitization on health matters
	Political	Very Active	Ward counselors	Spreading health information in the community
	Religious leader	Active	Catholic church and others	-Sharing of health information with church members -Catholic church supports some community groups
	Other	Active	Local commercial farmers	Provide transport during national health days
Nyimba	Traditional	Active	Village Headmen Chiefs (Ndake)	-Community sensitization -Communication of health information to communities
	Political	Not Active		
	Religious leader	Active	Church leaders	Spread health information to church members
	Other	Not Active		
Kalomo	Traditional	Very active	Chiefs (Chikanda, Siasimana, Simwatacela and Chitema)	-Community sensitization -Provide material and financial support to health programs
	Political	Partly active	Ward counselors	Sometimes help with organizing meetings in the community
	Religious leader	Active	Local church leader	-Spreading health information to church members -Training of HBC groups
	Other	Active	School headmasters	-Participate in HIV/AIDS activities -Health information sharing with parents and pupils
Lukulu	Traditional	Active	Village Headmen and Indunas Barotse royal establishment Chiefs (Kandombwe)	-Community sensitization -Supporting health programs -Gives permission to start programs in the area
	Political	Not active		
	Religious leader	Active	Catholic church (sisters)	-Help with health infrastructure development -Train HBC groups -Provides material support to vulnerable groups
	Other	Not active		
Kapiri	Traditional	Active	Village Headmen	-Community sensitization

Mposhi			Village committee	Organization of community during national health days
	Political	Not Active		
	Religious leader	Not active		
Mbala	Traditional	Headmen	Village Headmen (Landula)	Organizing of community members for health activities
	Political	Not active		
	Religious leader	Not active		
	Other	Not active		
Luangwa	Traditional	Active	Village Headmen Chiefs (Lumba)	Influence community participation in health services especially sanitation and child health
	Political	Partially active	Ward counselors	Organizing meetings in the community
	Religious leader	Active	Church leaders and elders	Information sharing with church members on health matters and spreading word on dates of ANC
	Other	Not active		
Zambezi	Traditional	Active	Village Headmen and Chiefs	
	Political	Not active		
	Religious leader	Active	Church leaders	-Sharing of health information to their church members -Supporting OVCs
	Other	Not active		

8.3 Summary of Interviews Done for the Community Mapping Exercise

District	In-depth Interviews DMO	In-depth Interviews Health Centers	FGD Community Groups	Total FGDs
Chiengi	DMO and Team			
Kabole Rural Health Center		Health center in-charge	NHC, + SMAG + TB supporter	3
Kalembwe Rural Health Center		Health center in-charge	CHW + TBA	2
Puta Rural Health Center		Health center in-charge	NHC + CHW + SMAGs	3
Total	1	3		8
Kapiri Mposhi	DMO and Team			
Kakulu Rural Health Center		Health center in-charge	NHC + TBA + child health promoters	3
Chawama Rural Health Center		Health center in-charge	NHC + child health promoters youth group	3
Nkole Rural Health Center		Health center in-charge	NHC + child health promoters	2
Total	1	3		8
Lufwnyama	DMO and Team			
Nkana Rural Health Center		Health center in-charge	NHC +TBA + CHW	3
Shimukunami Rural Health Center		Health center in-charge	NHC +lay counselors + CHW	3
St. Joseph Rural Health Center		Health center in-charge	NHC + CHW+ adherence supporters	3
Total	1	3		9
Kalomo	DMO and Team			
Mukewela Urban Health Center		Health center in-charge	NHC + CHW+ youth group	3
Chifusa Rural Health Center		Health center in-charge	NHC + nutrition supporters	2
MAWAYA Urban Health Center		Health center in-charge	NHC + CHW	2
Total	1	3		7
Nyimba	DMO and Team			
Hofmeyer		Health center in-charge	NHC + TBA + CHW	3
Chalubilo		Health center in-charge	NHC + TBA	2
Mtilizi		Health center in-charge	NHC + CHW	2
Total	1	3		7

Lukulu	DMO and Team			
Luvuzi Rural Health Center		Health center in-charge	NHC	1
Lubosi Rural Health Center		Health center in-charge	NHC + HBC giver	2
KAKULUNDA RHC		Health center in-charge	NHC + HCAC	2
Total	1	3		5
Luangwa	DMO and Team			
Bhoma Rural Health Center		Health center in-charge	NHC + CHW	2
Mpuka Rural Health Center		Health center in-charge	CHW	1
Kasinsa Rural Health Center		Health center in-charge	NHC + CHW	2
Total	1	3		5
Mbala	DMO and Team			
Kaka Rural Health Center		Health center in-charge	NHC + TBA/community-based birth attendant + CHW	3
Kawimbe Rural Health Center		Health center in-charge	NHC + CHW + SMAGS	3
Urban Rural Health Center		Health center in-charge	NHC	1
Total	1	3		7
Zambezi	DMO and Team			
Kucheka Rural Health Center		Health center in-charge	NHC + TBA	2
Mukandakunda Rural Health Center		Health center in-charge	NHC + CHW	2
Chilenga Rural Health Center		Health center in-charge	NHC + CHW	2
Summary Total	In-depth interview with district medical office and team			9
	In-depth interview with health center in-charge			27
	Focus group discussion with community groups			62

8.4 Health Center Advisory Committee Composition by Gender

District	Health Center	TOTAL	MALE	(%)	FEMALE	(%)
Chiengi	KABOLE RHC	10	8	80.0	2	20.0
	KALEMBWE RHC	15	9	60.0	6	40.0
	PUTA RHC	11	8	72.7	3	27.3
	TOTAL DISTRICT	36	25	69.4	11	30.6
Kapiri Mposhi	KAKULU RHC	38	27	71.1	11	28.9
	CHAWAMA RHC	17	12	70.6	5	29.4
	NKOLE RHC	14	9	64.3	5	35.7
	TOTAL DISTRICT	69	48	69.6	21	30.4
Lufwnyama	NKANA RHC	13	8	61.5	5	38.5
	SHIMUKUNAMI RHC	15	4	26.7	11	73.3
	ST. JOSEPH RHC	17	15	88.2	2	11.8
	TOTAL DISTRICT	45	27	60.0	18	40.0
Kalomo	MUKWELA UHC	14	7	50.0	7	50.0
	CHIFUSA RHC	11	8	72.7	3	27.3
	MAWAYA UHC	10	6	60.0	4	40.0
	TOTAL DISTRICT	35	21	60.0	14	40.0
Nyimba	HOFMEYER	10	6	60.0	4	40.0
	CHALUBILO	12	7	58.3	5	41.7
	MTILIZI	11	8	72.7	3	27.3
	TOTAL DISTRICT	33	21	63.6	12	36.4
Lukulu	LUVUZI RHC	12	7	58.3	5	41.7
	LUBOSI RHC	11	7	63.6	4	36.4
	KAKULUNDA RHC	15	10	66.7	5	33.3
	TOTAL DISTRICT	38	24	63.2	14	36.8
Luangwa	BHOMA RHC	10	6	60.0	4	40.0
	MPUKA RHC	15	9	60.0	6	40.0
	KASINSA RHC	18	13	72.2	5	27.8
	TOTAL DISTRICT	43	28	65.1	15	34.9
Mbala	KAKA RHC	9	8	88.9	1	11.1
	KAWIMBE RHC	9	6	66.7	3	33.3
	URBAN RHC	9	6	66.7	3	33.3
	TOTAL DISTRICT	27	20	74.1	7	25.9
Zambezi	KUCHEKA RHC	4	3	75.0	1	25.0
	MUKANDAKUNDA RHC	10	6	60.0	4	40.0
	CHILENGA RHC	11	7	63.6	4	36.4
	TOTAL DISTRICT	25	16	64.0	9	36.0
TOTAL		351	230	65.5	121	34.5

8.5 Study Tools

Ministry of Health (M)H) and Zambia Integrated Systems Strengthening Program (ZISSP)

Mapping of Health Resources

In-depth Interview Guide for District Health Office Technical Staff

Introduction

My name is ____*[your (the interviewer) name]*____, and this is my colleague ____*[the note taker's name]*____. We are working with the Ministry of Health (MOH) and the Zambia Integrated Systems Strengthening Program (ZISSP) to conduct an assessment of community health resources in ____*[District name]*____ District. We would very much appreciate your participation in this interview today to help us understand the status of health services across your district. From this exercise we hope to identify strategies to improve services and community participation.

The discussion will take about 1½ to 2 hours to complete, during which I will ask you several questions and ____*[the note taker's name]*____ will take notes on your responses. I will also be recording our discussion so that I can refer back to your responses at a later date. All of the information you provide to us today will be kept confidential and we will only be sharing your answers with the research team. Is this ok with you? *[Pause for individual to give you an answer]*

Please feel free to express your thoughts and opinions, as there are no right or wrong answers. Your answers will remain confidential and will not be attached to your name. Also, please speak loudly and clearly when answering the questions.

Do you have any questions before we get started? *[Answer any questions that the individual may have]*

Outline for in-depth interview guideline

Date of the Interview ____/____/____

Name of the District _____

Positions of respondent _____

Participation:

Section A: Community groups/Volunteers

1. What health -related community groups or volunteers do you work with in this district?
2. Of these community groups or volunteers, which ones are active in the provision of health services? Probe for community groups that have submitted reports/minutes at least once over the past one year or community group that has an administrative structure in place
3. What health services are the above mentioned active community groups involved in?

Section B: Stakeholders/Implementing partners

4. Which implementing partners (stakeholders) do you work with on health related issues in this district?
5. Of these implementing partners/stakeholders which ones are you currently working with in the provision of health services?
6. What type of support do you get from the above mentioned implementing partners/stakeholders support (support could mean: technical, financial resources, staff, or programme management?)

Section C: Planning Process

7. How are health centers involved in the planning process of health services in this district?
8. How are HC involved in the planning process of health services in this district?
9. How are stakeholders involved in the planning process of health services in this district?
10. How does the district ensure that HC activities are included in the district action plan?
11. What are some of the reasons why proposed health center activities are not included in the final district action plan?
12. How is budgeting decided during the planning process?
13. How approved activities and funding are communicated to health centers.
14. How does the district ensure that approved activities and funding are communicated to the community?
15. How do health centers access the allocated funds and resources?
16. What mechanisms are in place to ensure that allocated funds reach the intended beneficiary, such as the health center and/or community group?
17. What systems are in place to ensure that funds allocated for health center activities are used for their intended purpose?

Section D: Challenges in planning process

18. What are some of the challenges that the district face in the planning process?
19. What are some of the challenges that health centers face in the planning process?
20. What are some of the challenges that health centers face in involving community groups in the health planning process.
21. What do you think can be done to address these challenges?

Section E: Area of focus: Gaps in Service Delivery:

22. What health services are available in the district?

What health services are needed by the communities in this district?(Probe for Family Planning/Reproductive Health , Adolescent Reproductive Health , Malaria, Maternal and Child Health , Nutrition, Emergency Obstetric and Newborn Care, HIV/AIDS)

Section F: Behavior Change Communication (BCC) Materials and Activities

(These questions will be answered by the officer responsible for BCC activities in the district)

23. What types of BCC materials are distributed in this district?
24. Who develops the material?
25. What is the area of focus of the material?
26. Who is the target audience?
27. Who distributes the material?
28. Where are they distributed?

	Type of BCC Materials	Source	Subject matter/ health area	Target audience	Who distributes them
1.	Posters				
2.	Booklets				
3.	Leaflets/Brochures				
4.	Charts				
5.	Job Aides				
6.	Radio tapes				
7.	DVDs				
8.	CDs				
9.	Other:				
10.					

Type and source of BCC materials

[NOTE TO INTERVIEWER: Please collect any materials possible during this discussion.]

29. What mechanism exists to coordinate the distribution of BCC materials from the ministry of health and its partners to the health centers-?
30. How are materials replenished when they run out? (Probe who provides the materials and who is charge of requesting for more , when they ran out)
31. How do you identify which materials are needed in the district?
32. What would you say are currently the mostly used and needed BCC materials in the district?
33. What are the gaps in the existing BCC materials? (Probe for Types of materials, health areas, target audience)
34. How does the district communicate these needs to those producing the materials?
35. How relevant are the BCC materials you receive in relation to your needs.

-
36. What type of BCC activities do you have in the districts? (For example, community theatre performances, radio listening groups/clubs, video programs, etc.)
 37. What organizations implement BCC activities in this district? (Government: DHO, NAC / implementing partners: Corridors of Hope, SFH, Care, World Vision / FBOs, CBOs, etc.)
 38. What BCC activities do you provide during national health events (Child Health Week, World Health Day, Malaria Day, and World AIDS Day)?
 39. What other BCC activities would you like to see being provided in the district (probe for reasons)?
 40. What BCC activities do you have in the district action plan?
 41. What challenges exist in integrating BCC activities into the district action plan?
 42. What kind of support for BCC activities do you receive from the provincial office?
 43. What additional support in BCC would you need from the province?
 44. What support do you need to strengthen BCC planning and implementation in the district?
[NOTE TO INTERVIEWER: Ask for a copy of the action plan]

Section G: Capacity building and Training

45. Who oversees the implementation of BCC activities in this district? (Health promotion specialist, BCC expert, etc.)
46. What type of training did you receive to facilitate planning, implementation and monitoring of BCC activities?
47. What training do you need to effectively plan, implement and monitor BCC activities in the district?
48. Which stakeholders provide training in BCC to district staff?
 - a. (If training is provided by other stakeholders, how do they identify training needs)?

Section H: Health Management and Information System

49. How is community health information/data currently collected and reported in this district?
50. What challenges does the district face when collecting and reporting data from the health centers and communities?

Section I: Local Leadership and coordination

51. Who are the influential local leaders at the district level? **(Please indicate name and position)**
52. What is the role of these leaders in health care activities in the district?
53. What problems do you face as a district in coordinating community activities?
54. What could be the solutions to these problems?

Ministry of Health (MOH) and Zambia Integrated Systems Strengthening Program (ZISSP)

Mapping of Health Resources

In-depth Interview Guide for Health Center Management Staff

Introduction

My name is _____[*your (the interviewer) name*]_____, and this is my colleague _____[*the notetaker's name*]_____. We are working with the Ministry of Health (MOH) and the Zambia Integrated Systems Strengthening Program (ZISSP) to conduct an assessment of community health resources in _____[*District name*] _____District. We would very much appreciate your participation in this interview today to help us understand the status of health services across your district. From this exercise we hope to identify strategies to improve services and community participation.

The discussion will take about 1½ to 2 hours to complete, during which I will ask you several questions and _____[*note taker's name*]_____ will take notes on your responses. I will also be recording our discussion so that I can refer back to your responses at a later date. All of the information you provide to us today will be kept confidential and we will only be sharing your answers with the research team. Is this ok with you?
[*Pause for individual to give you an answer*]

Please feel free to express your thoughts and opinions, as there are no right or wrong answers. Your answers will remain confidential and will not be attached to your name. Also, please speak loudly and clearly when answering the questions.

Do you have any questions before we get started? [*Answer any questions that the individual may have*]

Date of the Interview _____/_____/_____

Section A: Health Center Demographics

1. What is the catchment population of this health center?
2. How many communities/villages does this facility serve?
3. How many communities/villages within the catchment population are not served by the health center?
4. How many communities/villages within the catchment area have limited access to health care services?

Section B: Community Groups/Volunteers

5. Please list the names of health -related community groups or volunteers you work with in this health facility? (Free listing)
6. (Probe for Health center committee, NHCs, TB supporters, FBO, Safe motherhood action groups, any other.....)
7. Of these **community groups or volunteers**, which ones are active in the provision of health services? (Probe for community groups that have submitted reports/minutes at least once over the past one year or community group that has an administrative structure in place .Use the pie picture to facilitate measuring activity)
8. What health services do the mentioned active **community groups** and/or volunteers support/ provide?

Section C: Stakeholders/Implementing partners

9. Which implementing partners (stakeholders) work with this health center on health -related issues in this catchment area? (Free listing)
10. Which ones are active in the provision of health services? (Use the pie picture to measure activity of stakeholders)
11. Do you have a Health Center Advisory Committee (HCAC)?
12. What are the roles and responsibilities of the Health Center Advisory Committee (HCAC)? (Ask for a copy of the roles and responsibilities, Probe for meeting frequency for HCAC)
13. **Kindly tell me the composition of the HCAC by**

No	Office Bearers	Composition by gender	
		Male	Female
	Chairperson		
	Vice-Chairperson		
	Secretary		
	Vice- Secretary		
	Treasurer		
	Vice Treasurer		
	Committee members		

Section D: Planning Process

Participation

14. What is the role of the health center in the community health planning process?
15. Which community groups and/or volunteers participate in the community health planning process?

-
16. Please describe how community groups and/or volunteers are involved in the community health planning process? (Probe for Roles and the steps for getting involved)
 17. What type of guidance do community groups receive about the community health planning process? **(Probe for when they receive guidance and the type of guide given (get copy of guide if available)).**
 18. When the community groups submit the activities, how do you select the activities which are going to be included in the consolidated health center action plan?
 19. Why are some proposed community activities not included in the final health center action plan?
 20. How approved activities and funding are communicated to community groups that participated in the health planning process? (probe activities and funding separately)
 21. How is budgeting done during the community health planning process?
 22. How do community groups access funds and resources for the planned activities?
 23. What systems are in place to ensure that funds allocated for community activities are used for the intended purpose?
 24. What mechanisms are in place to ensure that funds/materials allocated for community services reach the community groups in charge of implementation?

Section E: Challenges in the planning process

25. What are some of the challenges that this health facility faces in the planning process?
26. What are some of the challenges that this health center faces in involving HCAC and/NHCs in the health planning process?
27. What are the challenges specific to involving community groups in this process?
28. What do you think can be done to address these challenges?

Section F: Area of Focus: Service Delivery Gaps

29. List health services which are offered in this catchment area? **(Free listing)**
30. Which of these services are doing well and which ones are not doing well?**(Probe for reasons)**

Section G: BCC Materials and Activities

31. Could you list types of BCC materials that the health center receives from the district or other sources? **(For each Probe for the source, place of distribution and gaps)**
32. Who are the implementers of BCC activities in the health center catchment area? **(Probe for NHCs, SMAGs, FBC, Theatre groups, etc)**
33. For the above mentioned implementers, what type of BCC activities do they carry out? **(List the implementer above and match with activity)**
34. What BCC activities do you provide during Child Health Week, World Health Day, Malaria Day, World AIDS Day and other national events?
35. What other BCC activities would you like to see being provided by the health center. Give reasons why
36. How are BCC activities integrated in your health center action plan?
(Probe for challenges to integrating BCC activities into this plan, ask for copy of action plan)
37. How do you monitor the effect of BCC materials by the health center in this catchment area?
38. If they are other partners in these areas how does the health center know if BCC activities being implemented in the catchment area of this center
39. What support do you need to strengthen BCC planning and implementation in the community?

Section H: Monitoring and Supervision of community activities

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40. Do community groups report to the health facility?
 41. What reports do you receive from the community groups?
 42. What registers/tools do community groups use for reporting?(free listing)
 43. how the information/data is collected from the community groups is used at the health center?
 44. What tools do you use to conduct supervision/monitoring of community activities? (ask for evidence)
 45. What challenges does the health facility face on collecting reports from the community?
 46. What challenges does the health facility face on reporting and data collection from the community groups (Ask for the tools if available)

Section I: Capacity Building

47. Do you provide any training for community groups in this area?
48. What type of training do community groups receive to enable them carry out their work?
49. Who provides the training? E.g. the health center
50. If you are the ones who provide the training what preparation did you receive to enable you conduct the training for the community groups?

Section J: Local Leadership and Coordination

51. Who are the influential local leaders in your catchment area
52. What is the role of these leaders in health care activities in this catchment?
53. What problems do you face as a health center in coordinating community activities?
54. What could be the solution to these problems_

**Ministry of Health (MOH) and Zambia Integrated Systems Strengthening Program (ZISSP)
Mapping of Health Resources**

Focus Group Discussion (FGD) Guide for Community Groups

Instruction: The FGD will be made up of 6 - 8 members of the community

Introduction

My name is _____ and I am working with Ministry of Health in collaboration with Zambia Integrated Systems Strengthening Program (ZISSP). We are conducting an assessment on various health issues. We would very much appreciate your participation in this exercise. The discussion will take about 1 hour 30 minutes to 2 hours to complete. Please feel free to express your opinions and views, as there are no wrong answers. All views are confidential.

This mapping exercise is being undertaken by the MOH in partnership with ZISSP to gather information of the situation of health services at community level. Your participation will help in understanding the status of health services and identify strategies to improve services and community participation.

I will be recording this discussion on audio to enable me write a report later. Do not worry about the recording as your names will not be used in the report just a summary of all the views discussed here. So do not let the recording bother you but please talk one at a time to enable accurate recording.

Outline for in-depth interview guideline

Date of the Interview ____/____/____

Name of the District _____

Positions of respondent _____

Participation

Section A: Community Volunteers

1. What health -related community groups or volunteers do you work with in this community?
(probe for women and youth groups)
2. Of these community groups or volunteers, which ones are active in the provision of health services?
(Probe for community groups that have submitted reports/minutes)
3. What health services does your group provide?
4. Do you submit reports for your activities (probe for the last time the report was submitted?)

Section B: Stakeholders

5. Which implementing partners (stakeholders) do you work with on health related issues in this community?
6. What health services do these partners provide?
7. Of these **implementing partners**/stakeholders which ones are you currently working with in the provision of health services now?
8. What type of support do you get from the mentioned implementing partners/stakeholders (support could mean: technical, financial resources, staff, or program management?)

Section C: Planning Process

A. Participation

9. How is your group involved in the planning of health services in this community?
10. How are stakeholders involved in the planning of health services in this community?

B. Inclusion and allocation criteria

11. How does your group ensure that community activities are included in the health center action plan?
12. What are some of the reasons why proposed community activities are not included in the final health center action plan?
13. How approved activities and funding are communicated to the community groups like yours?
14. How do community groups like yours access these funds and resources?
15. Do you think the funds and resources allocated to community groups reach the intended beneficiary, such as your groups
16. What systems are in place to ensure that funds allocated for community activities are used for their intended purpose?

C. Challenges in planning process

17. What are some of the challenges that community groups like yours face in the planning process?
18. What challenges do community groups like yours face in working with HCAC/NHCs in the health planning process
19. What challenges do you face in working with other community groups in this planning process?
20. What do you think can be done to address these challenges?

Section D: Gaps in Service Delivery:

21. What health services are available in this community?
22. Which services are doing well and which services are not doing well (probe for reasons)
23. What health services are needed in this community?
(Probe for FP/RH, Adolescent RH, Malaria, MCH, Nutrition, EmONC, HIV/AIDS)

Section E: Behavior Change Communication (BCC) Materials and Activities BCC Materials

24. What types of BCC materials does your group distribute in this community?
25. Where do you get the materials from?
26. What is the area of focus of the materials do you distribute? (probe for commonly distributed materials that concern women and youths)
27. Who is the target audience? (probe women and youths)
28. Are there any other groups distributing the material? (list the groups)
29. What kind of materials do they distribute (probe for which materials are commonly understood, note for women and youths).

[NOTE TO INTERVIEWER: Please collect any materials possible during this discussion.]

30. What mechanism exists to coordinate the distribution of BCC materials from health centers to the community groups?
31. How are materials replenished when they run out? Probe for who distributes and who is in charge.
32. What would you say are currently the most needed BCC materials by communities (probe for what is needed for women and youths)
33. What are the gaps in the existing BCC materials?(probe for content, type, appearance, mode of distribution)
34. What type of BCC activities do you have in the community? (For example, community theatre performances, radio listening groups/cubs, video programs, etc.)
35. What organizations implement BCC activities in this community? (Government: DHO, NAC / implementing partners: Corridors of Hope, SFH, Care, World Vision / FBOs, CBOs, etc.)
36. What BCC activities do you provide during National health events (Child Health Week , Malaria Day, World AIDS Day World Health Day)
37. What other BCC activities would you like to see being provided in the community (probe for reasons)
38. Are BCC activities in your action plan integrated in the health center action plan-?
39. What challenges exist in integrating BCC activities into the health center action plan?
40. What kind of support for BCC activities do you receive from the health center
41. What additional support in BCC would you need from the health center?
42. What support do you need to strengthen BCC planning and implementation in the community?

[NOTE TO INTERVIEWER: Ask for a copy of the plan]

Section F. Training

43. Has your group received any training in conducting bcc activities
44. What training have your group received in conducting BCC activities
45. Do you need any additional training in conducting bcc activities (
46. What type of training does your group need?
47. Which stakeholders provide training in BCC activities for community groups?

Section G: Health Management and Information System

48. What tools do you use to collect information in the community
49. What challenges does your community group face in collecting and reporting data to the health center?

Section J: Local Leadership and Coordination

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50. Who are the influential local leaders in your catchment area (Please indicate name and position)
 51. What is the role of these leaders in health care activities in this catchment area?
 52. What problems do you face as a community groups in coordinating community activities?
 53. What could be the solutions for these problems?