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World Vision Relief and Development, Inc.

**WVRD/Zambia FY96
CS XII Detailed Implementation Plan
Gwembe Valley Child Survival Project
April 14, 1997**

Beginning Date: October 1, 1996
Ending Date: September 30, 2000

Submitted to:

Child Survival Grant Program
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List of Abbreviations

ADP	Area Development Program
ARI	Acute Respiratory Infection
CBH	Central Board of Health
CDD	Control of Diarrheal Disease
CHW	Community Health Worker
CS	Child Survival
CSP	Child Survival Project
DAC	Development Assistance Center
DHMT	District Health Management Team
DIP	Detailed Implementation Plan
MOH	Ministry of Health
EPI	Expanded Program on Immunization
FP	Family Planning
GM	Growth Monitoring
GVCSP	Gwembe Valley Child Survival Project
HAF	Home Available Fluid
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IGA	Income Generating Activity
IMR	Infant Mortality Rate
KPC	Knowledge, Practice and Coverage
MCH	Maternal/Child Health
MOH	Ministry of Health
NHC	Neighborhood Health Committee
NGO	Nongovernmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PLA	Participatory Learning Appraisal
PVO	Private Voluntary Organization
SSS	Sugar/Salt Solution
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
TDRC	Tropical Disease Research Center
TOT	Training of Trainers
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
UTH	University Teaching Hospital
WASHE	Water, Sanitation and Health Education
WCBA	Women of Childbearing Age
WHO	World Health Organization
WVI	World Vision International
WVRD	World Vision Relief and Development
WV-Z	World Vision of Zambia

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**DETAILED IMPLEMENTATION PLANS
GWEMBE VALLEY CHILD SURVIVAL PROJECT
WVRD/ZAMBIA**

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DIP TABLE A : FIELD PROJECT SUMMARY

PVO/Country : World Vision/Zambia
 Cooperative Agreement No. FAO-0500-A-00-6035
 Start date : October 1, 1996
 Estimated Completion Date: September 30, 2000

1. Percent of Total USAID Contribution by Intervention

Percentage must add up to 100%.

Intervention	Percent of Total Project Effort (%)	Percent of Total USAID Funds in US \$
Immunization	10%	62,738.00
Diarrhea Case Management	20%	125,477.00
Nutrition	-----	-----
Micronutrients	-----	-----
Pneumonia Case Management	-----	-----
Maternal Care	15%	94,108.00
Family Planning	15%	94,108.00
Malaria Prevention and Management	20%	125,477.00
HIV/AIDS Preventions	20%	125,477.00
Total	100%	627,384.00

2. Size of the Potential Beneficiary Population

Note : Potential beneficiaries are the individuals eligible to receive services under Child Survival funding. Females (ages 15-49 years) should only be included as direct beneficiaries of services (for example, TT immunizations or family planning services), and not for educational interventions (for example, education on proper use of ORT).

Current Population within each age group	Number of Potential Beneficiaries
Infants, 0 - 11 months	2,925
Children, 12 - 23 months	2,200
Children, 24 - 59 months	8,030
Females, 15 - 49 years	16,060
Total Potential Beneficiaries per Year	29,215

DIP TABLE B: PROJECT GOALS AND OBJECTIVES

PROJECT GOALS:

Expanded Program on Immunization

(1) Project Objectives by Sept. 2000	(2) Meas. Method for Objectives	(3) Major Planned Inputs	(4) Outputs	(5) Meas. Method for Outputs
1. At least 50% of mothers with children less than 2 years of age will know that their child should receive measles at nine months of age(baseline: 32%) ; and that tetanus vaccine protects both the mother and infant against tetanus (baseline: 27%).	KPC survey - Baseline and End of Project. Midterm Qualitative Assessment	a. Review EPI messages and develop and revise IEC materials (posters, etc) in collaboration with Regional health education unit, District Office, and UNICEF.	a. Contacts made with health education unit and UNICEF for review of existing EPI IEC messages and materials. Messages and materials tailored to project area needs.	a. Project Progress Reports. IEC materials present at health facilities and with community providers.
		b. Train health facility workers and community providers (CHWs, TBAs, neighborhood committees) in key messages and use of IEC materials related vaccine purpose and calender.	b. Health facility workers and community providers trained in key EPI messages.	b. Project Training Records and Progress Reports.
		c. Conduct health education sessions at the health facility, with outreach activities and at the village level for mothers, fathers, caregivers and leaders. Posters placed at schools where children receive tetanus booster.	c. Health education sessions regarding purpose of vaccines and vaccine calender conducted for mothers, caregivers, fathers and leaders at health facility sites, with outreach activities and through at the village level.	c. Project Training Records and Progress Reports. Site visits to observe health education activities.

<p>2. Maintain 80% complete immunization coverage for children 12 to 23 months of age and 50% coverage of WCBAs for TT5.</p>	<p>KPC Baseline and End of Project Survey.</p>	<p>a. Establish a written agreement with MOH and WV regarding roles and responsibilities for the delivery of outreach EPI activities (Gwembe - 32 delivery points and Sinazongwe - 35 delivery points) in the districts and plan of action for MOH to assume responsibility for all activities by the end of the project period.</p>	<p>a. Written agreement established with MOH defining collaborating responsibilities for delivery of outreach EPI activities. Plan of action designed to strengthen MOH to assume full responsibility for EPI intervention.</p>	<p>a. Project Progress Report. Review of written agreement of Plan of Action for responsibility transfer.</p>
		<p>b. As part of planning exercise, study seasonality influence on participation of outreach activities, capitalizing on increased amount of time to participate during dry season.</p>	<p>b. Focus groups with village members conducted related to seasonal availability of time for participation in outreach activities.</p>	<p>b. Project Progress Report. Review of data in relation to seasonality participation.</p>
		<p>c. Refresher course for health staff regarding documentation on health card, maintenance of cold chain, reducing missed opportunities and mobilization of community for outreach activities.</p>	<p>c. Staff refresher course for EPI intervention completed.</p>	<p>c. Project Training Records. Review of health cards during EPI service provision. Site visit to monitor cold chain maintenance.</p>

DIP TABLE B: PROJECT GOALS AND OBJECTIVES

PROJECT GOALS:

Diarrhea

(1) Project Objectives by Sept. 2000	(2) Meas. Method for Objectives	(3) Major Planned Inputs	(4) Outputs	(5) Meas. Method for Outputs
1. 10% increase in number of children with diarrhea in the past 2 weeks who were given the same amount or more fluids other than breastmilk. (baseline: 75%)	KPC Survey - Baseline, and End of Project Midterm Qualitative Assessment	a. Review and revise existing health messages and IEC materials related to diarrhea messages (hold focus groups to establish appropriate messages, collaborate with Regional health board health education unit, and BASICs ICMI materials)	a. Contact made with Regional health board, and BASICs. Focus groups for discussion and testing of messages completed. IEC messages and materials established, produced and distributed to health workers and community providers.	a. IEC materials present at health facilities and with community providers. Supervision site visits/materials in use.
		b. Train CHWs, TBAs, neighborhood committees, local leadership, traditional healers, women's development clubs and health facility workers in key diarrhea messages for home management.	b. CHWs, TBAs, neighborhood committees, local leadership, traditional healers, women's development clubs and health facility workers trained in key diarrhea messages for home management.	b. Project Training Records. Interviews with health facility workers and community providers regarding key CDD messages.

		c. Health education sessions for mothers and caregivers at static posts, before all outreach activities and at village level through community providers and for school children.	c. Health education sessions conducted for mothers and caregivers at health facility sites, with outreach activities and through community providers at the village level. (Biannually at primary schools)	c. Training Records Site visits to observe health education activities. Interviews with participants in villages regarding CDD knowledge.
		d. Liaison and collaboration with MOH regarding additional number of CHWs which can be formed and trained in outlying rural areas without access to health services.	d. Meetings with MOH conducted and agreement made regarding number of additional CHWs to be selected, trained and supervised and plans for their formation and training established.	d. Quarterly Progress Reports.

DIP TABLE B: PROJECT GOALS AND OBJECTIVES

PROJECT GOALS:

Malaria

(1) Project Objectives by Sept. 1999	(2) Meas. Method for Objectives	(3) Major Planned Inputs	(4) Outputs	(5) Meas. Method for Outputs
1. 10% increase in number of mothers who sought medical treatment for their child less than 24 months of age with fever in the past 2 weeks (baseline: 78%)	KPC Survey - Baseline, and End of Project Midterm Qualitative Assessment	a. Promotion of key health messages and development of IEC materials (hold focus groups to establish appropriate messages, collaborate with MOH health education unit, ICMI materials)	a. IEC messages and materials established, produced and distributed to health workers.	a. IEC materials present at health facilities and with VHWs. Supervision site visits/materials in use.
		b. Train CHWs, TBAs, neighborhood committees, local leadership, traditional healers, health facility workers and primary school teachers in key malaria messages for prompt care seeking practices.	b. CHWs, TBAs, neighborhood committees, local leadership, traditional healers, health facility workers and primary school teachers trained in key malaria messages for prompt care seeking.	b. Project Training Records. Interviews with community and facility based providers.
		c. Health education sessions for mothers and caregivers at health facilities, before all outreach activities, at village level through community providers, and for school children regarding key symptoms of malaria and need for prompt care seeking for treatment.	c. Health education sessions regarding key malaria messages conducted for mothers and caregivers at health facility sites, with outreach activities, at village level through community providers and at schools through teachers.	c. Training Records Site visits/Interviews with those conducting health education activities.

		d. Liaison and collaboration with MOH regarding additional number of CHWs which can be formed and trained in outlying rural areas without access to health services. (CHWs are able to supply firstline treatment for malaria.)	d. Meetings conducted and planned established with MOH regarding number of additional CHWs to be trained and plans for training of CHWs established.	d. Monthly Reports Supervision Site visits to observe CHW activities and malaria drug supply.
2. 25% of households (3,600) in target area using impregnated bednets by the end of the project period (baseline estimate - 2%)	IGA project sale records of mosquito nets; Household visits to observe net use.	a. Collaborate with MOH, UNICEF, and TDRC regarding net and chemical procurement.	a. Meetings and contact established with MOH, UNICEF and TDRC to obtain information regarding their mosquito and chemical supplier and estimated costs.	a. Monthly project reports. Name of suppliers identified and contacted.
		b. Purchase the nets and chemical and establish IGA groups for the manufacturing (sewing) and sell of the nets.	b. Nets and chemical purchased. IGA groups established (estimated 10 groups) for the manufacturing(sewing) and sell of nets.	b. Procurement records. Quarterly project report. Visit to IGA group.
		c. Training of IGA groups regarding promotion/ marketing/ redipping/ and sewing of nets.	c. IGA groups trained in the promotion, marketing, redipping and sewing of nets.	c. Quarterly project report. IGA group site visit.
		d. Train IGAs, CHWs, TBAs, clinic workers, neighborhood committees, village and church leaders in the purpose and benefits of using nets for the prevention of malaria and observe demonstration regarding use of the net.	d. IGAs, CHWs, TBAs, clinic workers, neighborhood committees, village and church leaders trained in the purpose and benefits of using nets and can provide return demonstration regarding use of nets.	d. Project quarterly reports. Training records. Interviews with staff trained to assess knowledge regarding nets.

		e. Health education sessions with communities with priority given to those living along the lake (target) regarding purpose, use and availability of nets.	e. Health education sessions conducted with communities regarding purpose, use and availability of nets.	e. Training records. Project quarterly reports.
		f. Supervision of IGAs and community visits to ensure 6 month redipping of nets	f. 3 - 6 month supervision visit conducted by project trainer for monitor of redipping nets and process of nets sales.	f. Project quarterly reports. Interviews with net owners to see if 6 month redipping occurred.
		g. Repurchasing of nets and chemicals as per stock demands and turnover.	g. Additional nets and chemicals purchased according to demand.	g. Procurement records. Inventory of stock.

DIP TABLE B: PROJECT GOALS AND OBJECTIVES

PROJECT GOALS:

Maternal Care

(1) Project Objectives by Sept. 2000	(2) Meas. Method for Objectives	(3) Major Planned Inputs	(4) Outputs	(5) Meas. Method for Outputs
1. 30% increase in number of women who can state at least 3 danger signs during the antenatal period and labor which require immediate assistance from a health professional. (baseline: 30%)	KPC Survey - Baseline and End of Project Midterm Qualitative Assessment (i.e. Quality Assurance Techniques, Health Facility Survey, Rapid Rural Appraisal Techniques.)	a. Review and establish key IEC maternal care and specifically danger signs during pregnancy/ labor and delivery messages in collaboration with Regional health education unit, and UNICEF (Safe Motherhood - Lusaka Unit).	a. Key IEC messages and materials for maternal care and dangers signs during pregnancy, labor and delivery established.	a. Project progress reports. IEC materials present at health facility and village level. Number of referrals received at health facilities.
		b. Train health workers, TBAs, community leaders, CHWs, and other women leaders in key maternal care/ danger sign messages.	b. Health workers and community providers and leaders trained in key IEC maternal care / danger sign messages and materials provided.	b. Project Training Records and progress reports. Interviews with health workers regarding key messages.
		c. Conduct health education sessions for mothers, caregivers, and household and community leaders at antenatal clinics and outreach sessions, and at village level through TBAs and other community providers.	c. Health education sessions conducted for mothers, caregivers, household heads regarding maternal care and danger signs during labor and delivery.	c. Project Training Records and progress reports. Interviews with village members regarding understanding of key messages.

	Refresher course on quality prenatal/postpartum and delivery assistance care.	d. Training and support for nurses serving at health facilities to provide supervision for TBAs in their service areas and prepared to receive referral patients showing signs of danger / problems during pregnancy and labor and delivery.	d. Trained nurses serving at health facilities and supervising TBAs in their service areas. Nurses aware and prepared to receive village referred cases.	d. Project Progress Records. Site visits for village interviews with TBAs regarding supervision and support received.
2. 20% increase in mothers who received two doses of TT before the birth of their youngest child less than 24 months of age. (Baseline: 63%)	KPC Baseline and End of Project Survey Midterm Qualitative Assessment	a. Monthly/quarterly meetings with district health team for the planning and implementing of facility and outreach vaccination activities for pregnant mothers and WCBA.	a. Monthly planning meetings conducted with district health team and vaccination activities implemented.	a. Project progress reports. Vaccination data/statistics. Site visits to observe vaccination activities.
		b. Conduct health education sessions for mothers and village members at facilities, with outreach activities and at the village level regarding purpose, benefits and calender for TT vaccine.	b. Health education sessions conducted regarding importance and calender for TT vaccine for pregnant mothers and WCBA.	b. Project training records and progress reports. Project site visits to observe health education activities.
		c. CHW and TBA follow up at village level based on community registries for mothers requiring completion of TT5.	c. Follow up being provided for mothers and WCBA overdue for TT vaccine.	c. Project site visits to discuss with CHWs and TBAs regarding use of community registries and follow up being provided.

<p>3. Establish village level referral transport support system through existing neighborhood committees.</p>	<p>Progress Reports Interviews with neighborhood committee members regarding effectiveness of support system.</p>	<p>a. Coordination with village headmen, leaders, churches, neighborhood committees and community providers regarding the purpose, benefits and support required for an emergency referral transport system for obstetrical and other medical emergencies arising among their village population.</p>	<p>a. Meetings conducted and support provided from village and church leaders, neighborhood committees and community providers for an emergency referral transport system.</p>	<p>a. Project Progress Reports. Number of emergency referrals received.</p>
		<p>b. Provide education for village and church leaders, community providers and community members regarding types of emergency complications which require immediate attention and referral to health facility site.</p>	<p>b. Education sessions conducted for village leaders, community providers and community members regarding criteria for emergency conditions requiring immediate referral for medical attention.</p>	<p>b. Project Training Records and Project Progress Reports. Interviews with community leaders regarding knowledge on criteria for emergency medical cases.</p>
		<p>c. Provide guidance and on site assistance to neighborhood committees as they establish village supported referral transport system.</p>	<p>c. Guidance and on site assistance provided to neighborhood committee and village referral transport system established and functioning.</p>	<p>c. Project Progress Reports. Clinic site visits to discuss flow of referral cases. Village site visits to discuss effectiveness of transport support system.</p>
		<p>d. Facilitate linkage visits for community leaders and providers and neighborhood committees to meet referral site clinic staff and understand services available.</p>	<p>d. Community leaders and providers and neighborhood committees completed visits to referral site centers and relationships established with clinic staff.</p>	<p>d. Project Progress Report.</p>

		e. Outreach team to provide follow up with neighborhood committee for monitoring of functioning and effectiveness (addressing of constraints) of referral transport system.	e. Monthly site visits made by outreach team to dialogue with neighborhood committee regarding constraints and effective functioning of referral transport system.	e. Project Progress Reports. Site visits to dialogue with neighborhood committees.
		f. WV Zambia leadership actively seek additional resources for strengthening of referral sites within project area.	f. Contacts made by WV Zambia leadership with potential donor sources for the strengthening of obstetrical emergency referral site facilities.	f. Discussion with WV Zambia leadership regarding additional resources made available.

DIP TABLE B: PROJECT GOALS AND OBJECTIVES

PROJECT GOALS:

Family Planning

(1) Project Objectives by Sept. 2000	(2) Meas. Method for Objectives	(3) Major Planned Inputs	(4) Outputs	(5) Meas. Method for Outputs
1. 20% of mothers of children less than 24 months of age who desire no more children in the next two years or who are not sure, who are using a modern contraceptive method. (Baseline: 9.8%)	KPC Survey - Baseline and End of Project	a. Review, revise and development key child spacing messages and IEC materials in collaboration with Regional health education unit and JSI FPS initiative. Conduct focus groups with village men and women regarding sexuality / reproductive health, perceptions and current understanding of child spacing.	a. Contacts made with Regional health education unit and JSI FPS. Focus groups on reproductive health conducted. IEC messages and materials established, produced and distributed to health workers and community providers.	a. IEC materials present at health facilities and with community providers.
		b. Refresher training for family planning providers (health center and outreach team midwives) in counseling skills and types and specific characteristics of each method.	b. Refresher training for family planning providers completed.	b. Training Records. Facility site visits to observe family planning services.
		c. Training for midwives, TBAs, CHWs, community leaders, church leaders, men groups, neighborhood committees on key child spacing messages and services available.	c. Midwives, TBAs, CHWs, community and church leaders, neighborhood committees trained in key child spacing messages and services available.	c. Project Training Records. Interviews with providers to evaluate knowledge regarding key child spacing messages.

		d. Health education sessions for men and women at the village level regarding benefits of child spacing, types of methods and availability of services.	d. Health education sessions regarding child spacing and available services conducted at the facility level, with outreach activities and at the household level.	d. Project Training Records. Project Progress Reports. Site visits to observe health education activities.
		e. Collaborate and follow up with MOH MCH district department regarding training and supervision and supplies for CBD agents (JSI Family Planning Services Project) in project area. (Estimate for training 30 per district)	e. Meetings conducted and agreement made with MOH MCH district departments for number of CBDs to be trained and plan for their supervision and material supply.	e. Project Progress Reports. Discussion with MOH MCH district supervisor.
		f. Conduct training for CBD agents and supervisors and provide necessary supplies.	f. CBD agent and supervisor formation and training completed and supplies distributed.	f. Project Training Records and Progress Report.
		g. CBD supervisors monthly supervision visit to field site for CBD agent activities, replenishing of supplies and data collection.	g. Monthly supervision of CBD activities completed. CBD supplies restocked and data collected on a monthly basis.	g. Project Progress Reports. Site visits to interview CBD agents regarding support received and adequacy of stock supply.

DIP TABLE B: PROJECT GOALS AND OBJECTIVES

PROJECT GOALS: HIV/AIDS

(1) Project Objectives by Sept. 2000	(2) Meas. Method for Objectives	(3) Major Planned Inputs	(4) Outputs	(5) Meas. Method for Outputs
<p>1. Provide support to district HIV/AIDS coordinator for implementation of annual plan with specific targeting for the formation and strengthening of Anti-AIDS clubs, and workshops for health workers, community leaders and other groups regarding key issues related to HIV/AIDS in the project districts.</p>	<p>Mid-term Evaluation exercises - interviews with AIDS coordinator, # of Anti-AIDS clubs formed, functioning and receiving regular supervision, review list of workshop participants and project quarterly reports.</p>	<p>a. Conduct series of meetings to review annual plan in collaboration with AIDS coordinator and specify specific areas of support to be received from the project.</p>	<p>a. Meetings conducted with districts AIDS coordinators and agreement made regarding how project will support the implementation of the HIV/AIDS annual plan for the districts.</p>	<p>a. Quarterly progress reports. Interviews with district AIDS coordinator.</p>
		<p>b. Assist with planning and determining the necessary resources for the establishment, training, and supervision of AIDS club at each primary and secondary school in the project area.</p>	<p>b. Agreement made and support provided for the establishment, training and supervision of AIDS clubs at primary and secondary schools in the project area.</p>	<p>b. Quarterly Progress Reports. Field site visits to primary and secondary schools to observe Anti-AIDS club activities.</p>

		c. Provide planning and resource assistance for the implementation of one workshop per year per district for health workers, church leaders, community leaders to address critical issues related to HIV/AIDS transmission and disease in the project districts.	c. Planning and resource needs determined in collaboration with district AIDS coordinator for implementation of yearly workshop.	c. Project Training Records. Project Annual Report.
		d. Provide PRA training for AIDS Coordinator.	d. District AIDS coordinator participated in project and district health workers PRA training exercise.	d. Project Training Records. Progress Reports.
2a. 30% increase in mother's knowledge regarding protection of oneself and partner against HIV/AIDS. (baseline: 55%)	Baseline and End of Project KPC survey. Midterm Qualitative Assessment	a. Conduct focus groups to discuss current attitudes, beliefs and practices regarding risk of HIV and understanding of disease transmission and prevention.	a. Focus groups conducted with community members regarding attitudes, beliefs and practices regarding HIV/AIDS transmission/prevention.	a. Quarterly and annual progress reports.
2b. 85% of fathers know how to protect themselves and their partners against HIV/AIDS. (No baseline)	Knowledge Survey among men 18 to 65 years of age to be done at beginning of intervention and at end of project period.	b. Collaboration with Regional health education unit, Red Cross and other groups working in HIV/AIDS for review and development of key IEC messages related to HIV/AIDS.	b. Contact made with Regional health education unit, Red Cross, etc. to review existing IEC HIV messages and messages with input from focus groups established.	b. Quarterly and annual progress reports. IEC materials present at project office and at facility and village level.
		c. Train health facility workers, community providers, community leaders in key messages related to HIV/AIDS prevention and transmission.	c. Health facility workers, community providers and community leaders trained in key IEC HIV/AIDS messages.	c. Project training records. Interviews with health and community providers regarding key HIV/AIDS IEC messages.

		d. Conduct health education sessions/ discussions groups at facility, with outreach activities and at village level regarding the prevention and transmission of HIV/AIDS.	d. Health education sessions regarding HIV/AIDS transmission/ prevention conducted at health facilities, with outreach activities, and at village level.	d. Project training records. Quarterly progress reports. Site visits to observe education activities.
		e. Planning and coordination with district AIDS Coordinator for the establishment of groups among men regarding HIV/AIDS prevention.	e. Coordination meeting conducted with district AIDS coordinator, plan established and groups formed for men to dialogue and increase knowledge and promote behavior change regarding HIV/AIDS prevention.	e. Quarterly and Annual progress reports. Site visits to observe men's groups discussions.
		f. Establish plan with district AIDS coordinator for appropriate distribution channels for the supply/sale of condoms. (Collaborate with PSI and other NGOs/organization doing similar interventions in other areas of the country to exchange of ideas.)	f. Establish plan with district AIDS coordinator for appropriate distribution channels for the supply/sale of condoms. (Collaborate with PSI and other NGOs/organization doing similar interventions in other areas of the country to exchange of ideas.)	f. Interviews with District AIDS coordinator. Project progress reports. Site visits to observe distribution channels for condom supply.

		g. Train two leaders (one man and one woman) from each village in counseling for HIV/AIDS issues and concern.	g. Two leaders from target villages trained and providing information/counseling for village members in relation to HIV/AIDS issues.	g. Project training records. Interviews with village HIV/AIDS counselors regarding current skills and activities.
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C. PROJECT LOCATION

C1. Location Maps (See Annex A)

C2. Location Description

The project area is situated within Southern Province, approximately 200km from the capital, Lusaka. The targeted area includes Gwembe and Sinazongwe Districts which are located along Lake Kariba, the largest man-made lake which borders the two districts on the north and Zimbabwe on the south, and have a total population of 146,000. The project will serve approximately half of the districts population with its community based initiatives and outreach services. The total number of beneficiaries is 29,215. The district of Gwembe covers a surface area of 12,611 sq km, while Sinazongwe covers an area of 15,384 sq km. The project area referred to as “Gwembe Valley” is very hot and dry and receives the lowest rainfall in the country and is known for its poverty conditions. The predominant ethnic group in the area is the Tonga who characteristically live in homesteads rather than typical villages. The majority of the population is Christian and a smaller percentage Moslem. Most people are subsistence farmers producing maize, or sorghum (only one planting season per year resulting in periods of hunger.) Rainwater runs off immediately into the Lake Kariba, with little absorption into the land, making it very difficult to farm in these districts. Agricultural activity is further hampered by the extremely hilly and stony terrain: crops are often washed away with the run-off and only small fields are possible. Crop losses are also caused by birds (sorghum) and monkeys (maize) and people spend long hours trying to protect their fields. Villagers located along the lake are involved in fishing, and there is a small percentage of the districts’ population involved in cash crop production, mainly cotton. These income generating activities (IGAs) sometimes require men to be absent from their households for long periods of time as they go to the cities in search of markets to sell their products. The lake also attracts some individuals from the urban areas who come seeking fish products which can be taken back to their areas for marketing.

A patriarchal system exist among the Tonga and polygamy is a common practice with most men having an average of three to four wives. The population is not organized into typical villages, but is somewhat dispersed with each man having his “homestead” where he and his multiple wives, children and grandchildren live. Groups of these homesteads are considered a village. Access to primary schools has been improved over the past 3 years as WV-Z has facilitated the construction of primary schools in rural zones in collaboration with the Ministry of Education and the local communities. The presence of and access to secondary school education for the two districts is very poor. The status of women is reflected in the low literacy rate in the local language (42.6%) together with early age of marriage (14-17 years of age). Young girls do have access to primary school but often leave school early to marry and conceive children or to assist with the younger siblings. Girls go through initiation ceremony at 12 to 15 years and usually leave school to marry at that point. With the initiation, the young girls are kept inside their homes for a 3 to 4 month period and are not permitted to go out as they are in a time of “fattening” and grooming in preparation for marriage. Women are particularly vulnerable following the death of their spouse as tribal tradition allows everything to be taken from the widow by the husband’s family, including

the children who then become part of the deceased husband's brother's family.

The project site was targeted by WV-Z in collaboration with the Zambian MOH for implementation of the CS project as there are elevated levels of infant and child morbidity and mortality related to malnutrition, malaria, diarrhea and ARI and problems with food security. The national infant mortality rate (IMR) for Zambia is 108 per 1,000. The national under-five mortality is 191/1,000 and maternal mortality rate (MMR) is 202/100,000 (Situation of Children in Zambia, 1994). The total fertility rate in Zambia is 6.5%. No specific mortality rates for the districts are available. WV-Z began providing drought assistance to the "Valley" in 1982. Presently, WV-Z is working with 18,000 sponsored children in the project area. The targeted children are among the neediest in their communities and are assisted with basics such as education fees, school supplies, clothing, and health care. WV-Z supported by funding from Korea and UNICEF have been working to establish protected water sources for the districts with village maintenance and community participation ensured through the formation of water committees. Over the past 2 years, coverage for protected water sources has risen from 43% to 72% (KPC Baseline Survey, Feb. 1997) as a result of the water project. The area has been chosen by WV-Z for the establishment of an "Area Development Program" (ADP) which brings a 15 year commitment to facilitate and support community development initiatives.

The constraints to health care delivery in Southern Province are many: the "hilly" terrain with poor road infrastructure (further complicated during the rainy season), villagers' poor access (distance) to health facilities, and insufficient health staffing. Gwembe district has one hospital with laboratory services, 3 rural health centers offering basic primary care services and there are an additional two health centers being constructed by WV-Z for the District MOH which are near completion. Gwembe has a half-time physician who stays in Gwembe but has a private clinic in Monze and the district has a clinical officer and a senior nurse trained in diagnostic skills. Choma District Hospital (113 km away) serves as a referral site as it can provide c-sections and blood transfusions. Sinazongwe district has a central health center, 11 rural health centers (including those supported by the Momba Mining Company) and a hospital is being built with support from the World Bank. A summary of health care institutions in the project area can be found in Annex B. The outpatient department of this hospital is in operation. Sinazongwe has two physicians who work with the copper mines. Maternal and child health nurses are concentrated in Momba (Sinazongwe District), a mining town, but outlying rural areas have very, very few health staff. Most villagers live beyond 12km of the nearest health center and some are located up to 50 km away. The two districts' supervisory and referral system is poor due to insufficient staffing and lack of transport and fuel. Drug supply in the districts is often inadequate as the essential drug kits provided are not based on population being served. The existing relationship between WV-Z and the District MOH and Momba Mining Company are positive. The CSP has its office in the Gwembe District Health Department for Gwembe and in the Momba Mining Company office for Sinazongwe. All training and outreach activities are conducted in a joint fashion.

Section D. PROGRAM DESIGN

D.1 Summary of Overall Program Design

The main goal of the project is the same as that of Zambia's National Program of Action, to reduce maternal, infant, and child morbidity and mortality through the provision of basic primary health care services as close to the household level as possible. To achieve this goal, the project's approach will be to: 1) build the capacity of the District Health Management Team (DHMT) to improve, expand, and supervise the community based infrastructure for primary health care promotion; 2) support the DHMT to assume their new role under Zambia's health care reform by enhancing their skills in the planning, management, and delivery of quality health services in key health interventions; 3) collaborate closely with other USAID and donor funded initiatives to ensure that these districts benefit from training, materials, and approaches being used elsewhere in Zambia. Dr. Katele Kalumba, Minister of Health, is looking to this project as a potential model for future PVO/District coordination to achieve the national health objectives. A secondary goal is for World Vision to further build the technical and management capacity of WV- Z staff in child survival interventions. Successes can be further replicated through the WV-Z ADP structure, which includes nine geographical areas within the country.

The project has revised and refined its design based on the technical feedback received during the USAID review of the Gwembe Valley Child Survival CSXII Project (GVCSP) Proposal in June 1996. The most major change is that the project will serve approximately half of the two districts with its community-based initiatives and outreach support. This change was made to address the concern that the project was overly ambitious for such a remote and difficult to serve area. This change also helped to better match the scope of the project with the resources available. These issues have been addressed in Annex C.

The approach described above has been developed based on the needs and gaps in the district health system in the two districts as well as the needs expressed by the community. The **first** major need is for promotion of community and household healthcare behaviors in the two districts. This need is evidenced by the lack of community based providers and neighborhood committees in the two districts. Currently there are only 105 CHWs serving in Sinazongwe and 85 in Gwembe serving a combined population of 145,000 (1 CHW per 763 persons.) There are also 56 TBAs serving in Sinazongwe and 52 in Gwembe (1 TBA per 1,343 persons.) There are approximately 25 neighborhood committees in Gwembe District and approximately the same number in Sinazongwe. Additional providers and committees are needed as well as improved supervision and training.

The need for this community based approach is also seen by the low level of current health knowledge and practice in the project area as revealed by the KPC survey results (see KPC Baseline Survey Report, Attachment I.) Dr. Ransome-Kuti expressed this need in his World Bank presentation on the Zambia health care reform, by stating that: "*There is consensus that in most districts, it has gone as far as the health centers, and it needs to be pushed on into the community--villages, neighborhoods, health posts; this is where the transformation must take place for the reforms to have any effect on health status.*"

To respond to this gap, district health providers will be trained in community mobilization skills, health education methodologies, and key health messages as well as in the formation and supervision of community providers such as CHWs, TBAs, CBD agents, and neighborhood committees. Manpower shortages will be addressed by training new CHWs each year and by providing additional outreach personnel for supervision to supplement the severe shortage of health center staff. New and existing CHWs and existing TBAs will be equipped to provide basic services and health education and counseling in key child survival interventions on a regular basis in a manner which is easily understood and adopted by the communities. They will also provide on site surveillance for diseases and for acute illnesses/complications requiring immediate referral.

According to the Ministry of Health (MOH)¹ plan, neighborhood committees will be formed in communities with priority to be given to outlying rural villages. The role of these committees is to: 1) link the community with health center staff; 2) develop mechanisms for supporting and sustaining community-based volunteers; 3) collect relevant community based data; and 4) initiate and participate actively in health related activities at household and neighborhood level (see Zambia Health Sector Reform, Annex D.) These committees will be trained in skills related to problem solving and analysis and in the prevention of key contributors to village morbidity and mortality. Through the avenue of neighborhood committees, a village level support system for the transport of acute medical and obstetrical emergencies will be established. The community providers will be closely linked to the nearest local health center from which they will receive their material and supervision support.

A **second** major need in the project area is to equip the districts with the skills needed for decentralization. Decentralization has been put in motion without additional training for district managers in planning, budget management, supervision and team-leading skills. There is little to no supervision of the existing community providers. With the primary health care reforms, the nurses have adopted the “supermarket” approach whereby one provider follows the patient through the complete delivery of services. The motivation for the adoption of this type of service provision was to encourage integration of service delivery, however the reality has been long waiting lines and difficulty in organizing work loads and clinic flow.

To address this gap, the project will seek to strengthen the decentralized district health system through joint planning, training and supervision activities with the DHMTs for the effective delivery and improved coverage of primary health services with the critical involvement of community providers and members. The project’s finance and administrative staff will work with the DHMT

¹The Ministry of Health (MOH) recently established the Central Board of Health (CBH) to implement the decentralization process including: 1) providing health care through negotiated contracts with providers; 2) supporting providers by providing systems and training; 3) supervising providers by monitoring performance; 4) serving as a resource center providing technical assistance via time-limited projects; 5) integrating directorates and activities (instead of vertical programs.) The MOH will retain formulation of policy and standards. Since this division is still relatively new and not widely understood, this document will not distinguish between MOH and CBH and will use MOH for the sake of convenience.

to gain the budgeting skills necessary for them to properly prepare and manage their district budgets. District health staff will also be invited to participate in Participatory Learning Appraisal (PLA) techniques and in training related to Gender and Development issues. The PLA and Gender and Development skills are aimed at equipping health workers in promoting and providing behavior related/sensitive reproductive health interventions such as child spacing and prevention of STDs/HIV/AIDS with the vital involvement of men to ensure support at the household level. The HIS coordinator will work with the project staff and DHMT in the analysis and use of data for decision making and program management.

A **third** major need is access to health facilities and sufficient health staff to operate existing facilities, carry out outreach services, and supervise community health workers and neighborhood committees. A significant percentage of the population in the “Gwembe Valley” lives beyond 12km to the nearest health facility with some being located up to 50km distance away. MOH policy stipulates that villages that are 12 km or further away from a health facility should be reached by outreach health services. Using this definition, there is a great need for outreach services with 32 outreach points in Gwembe District and 35 in Sinazongwe District. With decentralization the Districts have only enough funds to cover half of the health staff needed and must downsize. Given this reality there is not sufficient manpower to serve these very under-served areas. As the districts devise ways to raise additional funds to support the needed health staff, the project will provide support for government-trained nurses to join District outreach teams to serve half of these outreach points for those portions of the population without access to formal health care and to assist with the supervision of the community providers. In addition, the district must learn to most effectively use the existing resources to have the greatest impact, and to establish priorities for reaching their goals.

For the district’s total population, there is only one hospital, 3 rural health centers (and an additional two health centers being constructed by WV-Z) in Gwembe and 1 central health center and 11 rural health centers (the majority supported by the Momba Mining Co.), and a hospital under construction (with World Bank support) in Sinazongwe. There are no referral sites which can provide blood transfusions, c-sections and other types of surgical interventions. WV-Z is funding the construction of two additional health centers through another source of funding, and will seek additional funds to upgrade at least one health facility per district to deal with obstetric emergencies.

The project will also play an important advocacy role in bringing resources and outside technical assistance to these districts. To do this, WV-Z will coordinate closely with other organizations and MOH national initiatives for the exchange of ideas and promotion and use of “best practices” in relation to community based primary health care. Active participation will take place with the NGO forum for organizations involved in health which provides an ideal opportunity to collaborate with USAID contractors such as BASICS and JSI who are also working in Zambia. Dialogue has begun with the Adventist Development and Relief Agency (ADRA) which is also implementing a CSP, and opportunities for cross project visits and training will be explored. The JSI “Family Services Project” (FSP) has already trained 2 project staff in the formation and training of CBD agents. Contact will be maintained with University Teaching Hospital (UTH) staff to seek out opportunities for training for trainers involved in the district. See section D.2 for further details.

D1.a Selection of Interventions

While assisting the districts to address these existing needs, the project will promote key interventions which address the main causes of child and maternal mortality in the project area. The main causes of child mortality in the project area are: diarrhea, malaria, ARI, and malnutrition/anemia. The main causes of adult mortality include malaria, pneumonia, pulmonary tuberculosis, and gastrointestinal infections. The last three causes of mortality are all related to high levels of HIV/AIDS mortality. Although there is not good maternal mortality data in the districts, the Zambian National Programme of Action states that the main causes of maternal mortality in Zambia are: anemia, sexually transmitted diseases (including HIV infection), toxemia, hypertension, malaria and complications of labor and delivery. Another important factor in choosing interventions is the Zambian MOH's six health thrusts. To move away from vertical programs, the MOH is promoting an integrated approach to the six health thrusts at the health center and community, in curative, preventive and promotive care (see Annex E.) The six health thrusts are:

- 1) safe motherhood and family planning
- 2) child health and nutrition
- 3) malaria
- 4) water and sanitation
- 5) tuberculosis
- 6) HIV/AIDS.²

Given the mortality data, the MOH health thrusts and the community-based KPC data, the project targeted the following interventions: Malaria Management, CDD, HIV/AIDS prevention, Maternal Care, Family Planning, and EPI messages and services to infants, children under five, women of child bearing age (WCBA) and the community in the project area. These interventions are essential components of community-based primary health care which targets and addresses the major causes of morbidity and mortality among the target population.

All WCBA and children under 5 will be targeted in community-based promotion efforts. These women, children, and newborns will enter and participate in the program through contact and follow-up with community health workers (CHWs), community-based distributors (CBDs) and traditional birth attendants (TBAs.) The CHWs and TBAs keep registers of all WCBA and children under five and will use these registers within their communities to track defaulters and to target interventions and provide referrals to those who are identified as high risk. Community-based distributors will target women of child bearing age and men for family planning services and education. Women, infants and children under five as well as other caregivers (especially grandmothers and older siblings) and household heads (men) will also participate in project activities through contact at the local health center, for curative as well as preventative services. (Refer to Annex B.) The target population and direct beneficiaries will also be targeted through outreach activities, neighborhood committees and community providers at the village and household level. Students will be targeted

²Nutrition will be targeted with another WV project. A water and sanitation in the target area is being funded by UNICEF. Tuberculosis is not a child survival intervention. The remaining health thrusts will be addressed in this project as well as diarrhea to complement the water and sanitation project.

for HIV/AIDS education through anti-AIDS clubs.

High Risk Populations for each Intervention

Malaria:

- Children under five manifesting fever or convulsions.
- Pregnant women, especially women in their first pregnancy, who have signs of malaria, particularly fever.
- Villages located on Lake Kariba where malaria incidence is particularly high

CDD:

- Children not being exclusively breastfed
- Communities which currently do not have access to a clean water source
- Children who are underweight following an episode of diarrhea
- Children less than 24 months of age suffering with diarrhea who are not given additional fluids or whose mothers stop breastfeeding or feeding the child

HIV/AIDS:

- Patients being treated for STDs
- Men involved in fishing activities and requiring trips to sell their product in urban markets
- Men and women in marriage relationships where condom use is not considered to be part of a "trusting" relationship

Maternal Care:

- Pregnant women who do not seek out antenatal care before the third trimester of their pregnancy or who make less than 2 antenatal visits during their pregnancy.
- Pregnant women who are located at great distances from the nearest health facility
- Pregnant women less than 18 years of age or over 35 years of age

Family Planning:

- WCBA with a child less than 2 years of age who do not want or are not sure they want a child in the next 2 years.
- Women under the age of 18 or over the age of 35

EPI:

- Children who are not fully immunized by the age of 12 months.
- Mothers who do not know the vaccine calendar schedule

D1.b Relationship with Other Non-BHR Funded Projects

Other WV-Z initiatives which will enhance the implementation and sustained impact of the CS interventions include a water and sanitation project, funded by UNICEF, and an agriculture and nutrition project, which is pending WV Canada funding. The water project has provided support for boreholes and latrine construction as well as sanitation education. The agriculture and nutrition project will include an intensive program of assistance to combat food insecurity in the region. WV-Z also has several other HIV/AIDS, nutrition and primary health care projects which are being implemented through Development Assistance Centers (DACs) which are in the process of being changed to ADPs for the exchange of ideas and training opportunities, and the project will also benefit from WV-Z expertise in PLA which is underway in other project areas. Finally, the

sponsoring of 18,000 children in the area has provided support for services such as the building of primary schools and health clinics in the zone as well as support for school fees and health costs.

D.2 Collaboration and Formal Agreements

The project has agreements with the District MOH offices of Gwembe and Sinazongwe for collaboration and implementation of the CS interventions. The goals and objectives of the project reflect the priorities of the district and provincial offices of health particularly in relation to the mobilization of primary health care (PHC) services and linkages with communities and community providers. The Gwembe District MOH has shown its commitment to the project by providing office space for project operations within their own government block of offices and by their involvement in the KPC and DIP planning.³ The current agreement established with the MOH is for the provision of fuel and additional staff support for half of these district's outreach points and provision of scales for growth monitoring and stop gap medicine supply to clinics, using GIK supplies. The MOH and the GVCSP will collaborate in training activities, and facilitators from the MOH offices will be used for training activities for the formation of CHWs and TBAs with the project providing the facilitators per diem. The project management and DHMT will meet for planning and management purposes every month.

The project also has a working agreement with the Momba Mining Company operations in Sinazongwe district who support the operation of nine clinics in the district. The company has provided office space for the project operations in their MCH department. The working collaborative relationship with the company is considered very positive.

WV- Z has been in contact with the *Environmental Health Project* (EHP) to discuss their work with the MOH on chloroquine resistance testing as well as the development of household and community-based approaches to malaria and diarrhea prevention. EHP works primarily with the DHMT in Kitwe District in Kitwe. EHP is working closely with other collaborators in the Copperbelt (BASICS, CARE, PSI, and EHP) to develop a locally initiated and integrated program of health promotion (see EHP objectives in Annex F.) Among other techniques, they are using Community Training, Assessment and Planning (CTAP), a BASICS developed process (see description in Annex G.) Together with neighborhood health committees and a working committee of the DHMT they are selecting emphasis behaviors and intervention strategies. A booklet for neighborhood health committees is being developed now and the project will be in touch with EHP to see if this booklet and other materials and approaches being developed in Kitwe could be adapted for use in Gwembe and Sinazongwe.

WV-Z has had several discussions and meetings with *BASICS* to see if the Gwembe and Sinazongwe Districts might benefit from the IMCI training that has begun in Zambia at two training

³The Gwembe District Health Director and Deputy Director participated in the KPC review and DIP planning workshop as well as the Executive Secretary of the Council and a Gwembe Traditional Chief. Sinazongwe District staff wanted to attend but were unable to participate because of another workshop. District nurses also participated in the entire KPC survey.

sites in Lusaka and Kitwe. Although space for the IMCI courses is limited and in high demand, BASICS Chief of Party is supportive of getting Gwembe and Sinazongwe district staff into the existing training courses being offered in Lusaka and Kitwe. Project Staff will participate in the review and planning of IMCI training for the next two to five years. The project will also approach the IMCI Advisory Committee to advocate for spaces for the district staff. District health staff may benefit from the IMCI training curriculum that BASICS is developing for lower level health workers. BASICS will also be available to provide technical assistance on supervision and reinforcing the critical link between health facilities and the community. The tools developed during their recent supervisory training for the promotion of quality delivery of services from health centers will be accessed and adapted. There are more opportunities to collaborate with BASICS community partnership work. BASICS' Community Mobilization Advisor is managing their small grants program with local NGOs. A community health worker curriculum is being developed and may be available for the project to use in training CHWs in Gwembe and Sinazongwe. Karabi Bhattacharyya of BASICS has developed the CTAP process (see above) to assist rural communities in Eastern Province to select priority prevention behaviors and develop a plan to promote these behaviors. BASICS has also learned from our PLA techniques that we will be using in the project area. They have recommended to the Zambian MOH that WV-Z and CARE be considered Centers of Learning for PLA and community based techniques. The project will review CTAP to determine whether there are useful components that could be added to the PLA training.

The project will continue to coordinate closely with *UNICEF's* water project in the project area. (See Annex H.) Community based diarrhea prevention messages will be phased in with the water teams education work, covering basic sanitation and hygiene measures. In addition, UNICEF is considering the launch of a country-wide initiative focusing on diarrhea, malaria, and ARI. WV is asking UNICEF to consider selecting Gwembe and Sinazongwe as they select 10 districts in 9 provinces for this project which will begin in Jan. 1998. This initiative will focus on household control measures and health education.

For family planning support, the *Finnish Volunteers* have raised \$4,000 for a CBD program. WV-Z will match this amount with approximately \$1,600 to initiate a CBD program. The project has been in contact with the JSI FSP and two staff have received training on the formation and supervision of CBD activities. The organization is committed to assisting WV-Z with guidance and technical support in the implementation of CBD initiatives. However, JSI is unwilling to provide financial support for the training for CBDs in the target area but is interested in starting a CBD initiative with WV-Z in Kitwe. The project hopes to apply the technical support and the model developed in Kitwe to Gwembe and Sinazongwe. *UNFPA* is not presently working in the Southern Province but are collaborating with WV-Z on an HIV/AIDS project in Zambia. They have been providing condoms for this project and this supply of condoms can also be used in the GVCS target area.

The Chikankata Hospital, a private hospital in the Southern Province operated by the Salvation Army, has taken a significant role in the country in training for home based care of AIDS patients and for the prevention and management of HIV/AIDS. Two of the project staff have been trained in the formation and supervision of HIV/AIDS counseling in the community.

The chiefs of the project area, the DHMT, district council management, health staff serving in the health centers and outreach team participated in the implementation and analysis of the KPC Baseline Survey and in applying the information to target DIP objectives and interventions during a DIP planning workshop.

D.3 Technical Assistance

The project will require technical assistance for HIS, PLA, CBD, IMCI, management skills, Gender and Development, and quality assurance. The following briefly describes the type of technical assistance to be provided:

KPC Survey:

WVRD regional technical support provided assistance with the training, implementation and analysis of the baseline KPC survey training. The project will send one individual from the project to the Training of Trainers (TOT) course conducted by the Child Survival Support Office at Johns Hopkins (JHU CSSP) in June, 1997. The WVRD regional technical support person also provided guidance and assistance in the development of the detailed implementation plan.

HIS and Evaluation:

The project will seek assistance from BASICS in effective use of the HIS in service management and evaluation. Contact will be made with other WV CSPs in Africa to exchange ideas and best practices in relation to community based data collection and community feedback mechanisms. External consultants experienced in decentralized district health systems will be brought in to lead the project midterm review and end of project evaluation.

PLA, Gender & Development:

WV-Z will be consulted for training in PLA techniques which will be used within the project communities to assist in the setting of community priorities and potential inputs. WVI regional technical person for Gender & Development & Policy Issues, Ms. Fatuma Hashi, will be brought in during the second year of the project to provide training for the area health staff and community providers.

CBD/Child Spacing:

The JSI Family Services Project will be consulted for continued guidance and materials for the implementation of CBD agent initiatives and upgrading of clinic child spacing services.

IMCI:

Contact will be maintained with BASICS to follow the development of initiatives related to IMCI and possible tested practices which can be implemented at the district site, and to seek out TOT opportunities for district staff in this approach.

Management Skills:

The Project Manager and Training Coordinator will be sent to attend a 3 week management course offered by a well known management training institution in the nation's capitol of Lusaka. As women are being placed in these roles, it is vital that opportunities be provided for the development of team leading, delegation and management skills as women in the country typically take a submissive role.

Quality Assurance:

WV is operating a number of CSPs in Africa and a core team has attended the Johns Hopkins

Quality Assurance Management Methods for Developing Countries. Opportunities will be sought to provide cross-country visits and training on the application of QA principles to facilitate the effective management of decentralized district health systems.

D.4 Detailed Plans by Intervention

D.4a Immunization

The project objectives for immunization to be reached by the end of the project period are: 1) At least 50% of mothers with children less than 2 years of age will know that their child should receive measles vaccine at nine months of age (baseline: 32%) and that tetanus vaccine protects both the mother and infant against tetanus (baseline: 27%); and 2) Maintain 80% complete immunization coverage for children 12 to 23 months of age and increase to 80% coverage of WCBA for TT5.

4a.1. Incidence and Outbreaks

In 1996, there was a measles outbreak in the Gwembe Valley which the MOH responded to with a mass campaign for measles immunization for children under five. The MOH district "EPI Monthly Reporting Form for Health Facilities on Morbidity and Mortality and General Information" collects information regarding the number of deaths and cases seen for measles, tetanus, and polio along with data regarding whether the child was vaccinated. No cases of neonatal tetanus or polio have been reported over the past year in the project area.

4a.2. Baseline Coverage Estimates

The KPC baseline survey coverage estimates for children 12 to 23 months of age was as follows: DPT1 - 93.8%; OPV3 - 88.4%; Measles - 84.9%. The current drop out rate (DPT1 - DPT3/DPT1) was measured at 8%. Children 12 to 23 months of age who were completely immunized (BCG, DPT123, OPV123, and measles) was 79.5%. TT2 coverage for mothers during their last pregnancy was 63.7% and TT5 coverage for WCBA was 51.9%. The complete immunization rates were comparable with the national average of 75%. Drop-out rates were also comparable at 10%. The National TT2 coverage for pregnant women was slightly higher than the project site at 76%.

4a.3. MOH Policies

The MOH strategy for immunization targets children 0 - 24 months of age (priority for children 0 - 11 months of age), pregnant women, WCBA (15-45 yrs old) and school children in grades I and VII. The strategy has 4 components defined as follows:

Strategy A: For static units immunization should be carried out at facilities which have a refrigerator and which provide MCH services. Immunization should be given to all target children at every contact with a health facility. The vaccine schedule for static units is:

- BCG at birth/1 dose;
- Polio at 2 months of age and continue up to 3 doses with a minimum interval of 28 days between doses;
- DPT at 2 months of age and continue up to 3 doses with minimum interval of 28 days

- between doses;
- Measles at 9 months/1 dose.
- Strategy B:** Mobile Units provide health services to population living outside 12 km radius of the health facility. Community should be involved in the planning of the outreach program. The vaccine schedule is the same as for the static units except that BCG can be given after 2 months if there is no scar.
- Strategy C:** Boosters at School Health Services schedule is as follows: for children entering school, BCG if there is no scar; dose of Polio and TT; for children in grade VII, BCG if there is no scar.
- Strategy D:** TT immunization of pregnant women and WCBA (15-45) with the following schedule:
- TT1 at first contact or as early as possible during pregnancy (even during 1st trimester);
 - TT2 at least 4 weeks after TT1;
 - TT3 at least 6 months after TT2 or during subsequent pregnancy;
 - TT4 at least 1 year after TT3 or during subsequent pregnancy;
 - TT5 at least 1 year after TT4 or during subsequent pregnancy.

All eligible women should get TT at antenatal clinics any time during pregnancy. All WCBA should be given TT at every contact with a health facility for any reason (curative service, when they bring their child in for immunization, family planning clinics at school health services). If a woman has documented TT5 history she is protected for a lifetime. Each TT dose should be recorded on the TT card and on the antenatal card (see card in Annex I.) Doses received prior to the pregnancy should be documented on the antenatal card from the TT card. If woman reports she received TT2 during her last pregnancy, then start counting the doses from TT3 even if there is no record of the two doses. Women who have record of 3 doses of DPT during childhood can be considered as having received 2 TT injections of the required 5. TT doses received through school health services can be included in the required 5 doses. There are no contraindications for children to immunization except symptomatic AIDS, in which case the child should not receive BCG but should receive all the other vaccines. The MOH currently conducts National Immunization Days/Campaigns which take place for one month each year.

4a.4 Knowledge and Practice

Knowledge regarding the purpose and schedule for vaccines was very low in the project area as revealed by the KPC Baseline Survey results. Mothers' knowledge regarding when the child should receive measles immunization was 32.2%. Only 27% of the mothers knew that TT is given to protect both the mother and the baby against tetanus. Only 5% of the mothers knew that at least 2 doses of TT is required during pregnancy before the birth of the child. The majority of the mothers (63%) thought that more than 2 doses are required, 4% of the mothers thought one dose is required and 26% of the mothers said they did not know how many doses are required.

Mothers actively participate in the immunization activities as can be seen by the acceptable complete immunization coverage rates and the reasonably low dropout rates.

4a.5 Approach

The existing constraints to achieving full immunization coverage in the program area include:

- *insufficiencies in the vaccine stock supply.* During different periods, the country's vaccine supply for particular antigens has experienced shortages.
- *access to services, especially for villages located at distances greater than 12 km from the nearest health post.* These communities are inaccessible for a few months each year as the roads and streams become impassable due to rains. Ensuring adequate transport is always a problem as the vehicles are usually needed for several activities.
- *mothers' knowledge regarding vaccine schedule and purpose of vaccines is low and could affect participation and care seeking.*
- *the majority of infants are delivered at home.* Therefore health education for mothers to bring their infants in to start immunizations needs to be further encouraged.
- *low staffing coverage in the district,* with some nurses required to work 24-hour shifts. This situation makes it difficult to provide thorough care and make the most of every opportunity when children contact the health services. The project is assisting with staff support for the delivery of outreach activities, but a clear plan of action will need to be designed with the district MOH to ensure that these positions are budgeted for by the 3rd and 4th years of project implementation.

The quality of services is considered high in relation to cold chain system, card documentation, and injection technique (including sterile supplies). Health education regarding immunization requires strengthening.

The project will review, revise and strengthen EPI messages and IEC materials in collaboration with the Regional health education unit, District Office, and UNICEF. Emphasis will be placed on effective means of assisting mothers to learn/remember the vaccine calendar and number of doses required for each antigen. Health facility workers and community providers (CHWs, TBAs, neighborhood committees) will be trained in the key messages established, and in the use of IEC materials and education methods related to vaccine purpose and calendar. These workers will be mobilized to provide health education sessions at the health facility, during outreach activities and at the village level for mothers, fathers, other caregivers and community leaders. Posters will be placed at schools where children receive a tetanus booster, focusing on grades I and VII.

The project management will establish a written agreement with the District MOH and WV-Z regarding roles and responsibilities for the delivery of outreach EPI activities (Gwembe - 16 delivery points and Sinazongwe - 18 delivery points) in the districts, and will develop a plan of action for DHMT to assume responsibility for all activities by the end of the project period. The project will initially support 2 outreach team members per district and will assist with transport needs for the implementation of outreach activities. As part of a planning exercise, a study of the seasonality influence (rains) on participation of outreach activities will be done to consider how to best deliver services during this period of the year, and how to most effectively use the time available to villagers to participate during the dry season.

A refresher course for health staff regarding documentation on the health card, maintenance of the cold chain, disposal of needles, reducing missed opportunities and mobilization of community for

outreach activities will be conducted at the job site. Supplies for immunization activities are supplied by the district MOH and the project will only intervene in cases of emergency (after consulting with UNICEF). Vaccine supply will be maintained through adequate planning and timely requisitions using data gathered on population and number of vaccines provided. MOH already is using and will supply forms for this purpose. The project will also assist the MOH in advocating for and mobilizing a rapid response with the Regional MOH office, the National EPI/UCI Unit or UNICEF (the Lusaka Unit, and the Copenhagen office if necessary) in the event of an anticipated shortage.

4a.6 Individual Documentation and Monitoring System

The project will record immunizations on the MOH Children's Clinic Card (Annex J) which is also used for growth monitoring. The card supply has been sufficient and adequate through the district MOH system. Interestingly enough, the EPI Manual does not include instructions regarding filling in the EPI card or policy regarding what to do if the child's card is lost. The practice is to give the mother another card for the child and if possible record the dates the child was immunized from either the health center or CHW register. During mass campaigns or national immunization days, the vaccines given are not recorded on the card because health workers do not want mothers to think of the activity as a replacement for routine EPI services. TT injections for WCBA and pregnant women are recorded on both the antenatal and the TT card, which is MOH policy. All cards (infant's and mother's) are kept with the mother. Losing cards is not a significant problem in the project area, with survey results showing that only 3.7% of the mothers had lost their child's card and .3% of the mothers had lost their own card .

The MOH has tally sheets (see Annex K) which are used by the MCH teams for recording immunizations and collects data regarding type of antigen administered according to dose and age of child (two categories - under one or over one year of age). For TT it collects data regarding dose and whether the woman was pregnant. It also collects data for the number of children completing full immunizations according to age. The MOH also has a monthly reporting form for immunizations performed and stock control which collects data regarding: Total number of vaccines provided according to antigen/dose in two categories - static facility and outreach team; vaccine supplies according to stock existing from previous month, stock received during the month, amount used and wasted, and remaining stock according to each antigen. The form also has a category titled "other supplies" which records existing, received, used and current stock for syringes (specify ml), needles (specify gauge), paraffin, spare parts, immunization cards, and TT cards. The form used for vaccine disease surveillance which was mentioned earlier also requests data regarding present staffing at health facility and their involvement in EPI, number of places visited with outreach activities, and current condition of vaccine carrier, steam sterilizer, thermometer for cold chain control, and refrigerator.

4a.7 Drop-outs Children

The drop out rate for the project area is 8%. The main causes for drop out include: poor knowledge of mother/caregiver regarding vaccine schedule and number of doses required; mothers' need to travel far to services; outreach activities are provided only once a month for each site and are very

difficult to carry out during the rainy season; and staffing shortages which lead to long waiting periods for mothers arriving at the clinic. The project's strategy for reducing drop outs and for taking advantage of missed opportunities is to:

- 1) increase CHW and TBA follow-up of mothers and women who have been defaulting in the participation in services through supervision;
- 2) target health education at the health center during outreach and at the village level regarding purpose, calendar and availability of immunization services to assist mothers to become their own advocates for these services; and
- 3) provide additional staff for the outreach teams operating in the districts.

4a.8 *Drop-outs Women*

The strategy to be used to increase coverage for TT2 among pregnant women and TT5 for all WCBA is similar to the approach for addressing dropouts in children: 1) Current knowledge regarding the purpose and dose requirements for mothers is low and effective health education needs to be mobilized; 2) Health workers will receive refresher training at the job site regarding the need to use every opportunity to vaccinate WCBA with TT, even if they are coming to the health center or to the outreach services for another reason.

4a.9 *Population*

The beneficiary population for immunization of children is 2,425 for 0 - 11 months old (the priority group) and 2,200 for children 12 - 23 months of age (who are also in targeted in the MOH policy.) Based on a 3% growth rate using a total estimated population of 73,000, the estimated number of newborns each year is 2,190. The estimated number of children requiring a minimum of four visits for complete immunization is 4,025, with a total of 16,100 visits per year. The project will target both pregnant women and WCBA for TT injection. In the target area there are an estimated 32,120 WCBA.

4a.10 *Cold Chain Support*

The cold chain includes both kerosine, solar and electric refrigerators, depending on the location. The temperature of the cold chain is monitored twice per day and there is a standard form on which records for the entire year are kept on one sheet. Data includes temperature according to the date, and whether it is an AM or PM reading (refer to Annex K.) The districts have experienced some difficulties with refrigerator repairs, with equipment being taken away for repair and not being returned for several months. The solar refrigerators have been the least problematic and simplest to maintain. The kerosine refrigerators require more repairs and stocks of kerosine, paraffin and wick supply must be closely monitored. There is an adequate number of cold chain boxes for outreach activities. The staff member responsible for delivery of EPI services at the center is the same individual who is responsible for cold chain maintenance and monitoring. No studies regarding vaccine efficacy have been conducted in the project area. The project does not have plans to purchase any cold chain equipment as UNICEF has provided sufficient support to the country for this need.

4a.11 Surveillance

As mentioned earlier, the district MOH does have a surveillance reporting system in place for measles, polio and tetanus which is operated from the health centers. The MOH also has taken the responsibility for responding to epidemics and outbreaks and within the EPI Manual are standard case definitions of vaccine preventable diseases and guidelines for investigation and control of outbreaks. The project will support the health center and district management team in the analysis and use of this data in order to strengthen service impact.

4a.12 Community Support/Sustainability

The current community participation in outreach services and mass campaigns is very high. Communities contribute individuals who serve as CHWs and on the neighborhood committees who assist with mobilization activities. Leaders are called on to provide support for these community-based workers and to encourage their populations to attend the services being provided. There is no charge for the provision of vaccine services and cost recovery schemes for this activity have not yet been considered.

D.4b Diarrhea Case Management

The diarrhea case management intervention will closely collaborate with UNICEF's water and sanitation program in the two districts. The project will focus on appropriate case management in health facilities and appropriate care seeking and home based management of diarrhea as well as complement activities with resources from another source focusing on the prevention of diarrhea. The objective for CDD to be achieved by the end of the project period is a 10% increase in number of children with diarrhea in the past 2 weeks who were given the same amount or more fluids other than breastmilk (baseline measure: 75%).

4b.1 MOH Protocols

The MOH diarrhea case management protocol is based on 4 possible avenues of management, with the health worker guided to choose one response based on:

- 1) questions regarding child's symptoms (amount of diarrhea, presence and severity of vomiting, complaint of thirst, and presence and amount of urine);
- 2) physical examination of child looking for signs of severity of disease (assess presentation: alert, sleepy, etc., presence of tears, appearance of eyes and tongue, breathing);
- 3) checking skin turgor, pulse, and fontanelle;
- 4) temperature with observation for temperature above 38.5C;
- 5) child's weight and if records are available, assess growth;
- 6) decide which plan to use based on the degree/characteristics (A, B, C, D) of information collected (See Diarrhea Treatment Charts in Annex L.)

Treatment plan A provides the information that health workers need to communicate to mothers to prevent dehydration and to prepare ORS if needed.

Treatment plan B, which is a response for "some dehydration" focuses on treatment with ORS solution with the volume to be administered based on the child's weight and age and a reassessment of the child's status after 4 - 6 hours. The mother is given 2 packets of ORS and instructed in its

preparation and administration, in identifying signs of dehydration and to return to the clinic if these appear, as well as basic education regarding diarrhea prevention.

Treatment plan C is a response to signs of “severe dehydration” and guides the health worker in administering IV fluids and a reassessment after 4 - 6 hours. If IV fluids are not available, the health worker is instructed to give ORS solution based on the volume recommended under plan B using an NG tube if the child is unable to drink. An additional option is to send the child to a referral site where IV fluids can be administered. Reminders are given to instruct the mother how to cool the child if there is fever (wet cloth, fanning).

For home based care the MOH recommends increasing fluids that are available in the home, including rice water, *sump* soup (base is maize) or thin cereal based porridge, and home prepared SSS (although there is not sugar and salt available) along with continued breastfeeding and small and frequent meals. If the child is sick longer than 3 days or develops danger signs such as blood in the stool, the caregiver should take the child to the CHW or health center. The top MOH priorities for the prevention of diarrhea are:

- 1) good household hygiene with handwashing and latrine use
- 2) hygienic food preparation
- 3) breastfeeding

Actions/activities to decrease diarrhea morbidity and mortality include the following:

- 1) diarrhea prevention education
- 2) ORT corners
- 3) ORS packets (also available through CHWs)
- 4) use of home-based fluids
- 5) continued feeding
- 6) appropriate drug use and referral

For dysentery/persistent diarrhea cases the MOH protocol stipulates that nalidixic acid should be given and **Treatment plan D** is to be followed.

4b.2 Incidence and Distribution

Based on the KPC, the diarrhea prevalence among children less than two years old (measured for the 2 week period prior to the survey) is 35.9%. Diarrhea disease is highest from July to November when water supplies run low and the population is forced to use river beds and to dig shallow wells. During this period, hygiene practices decrease and they must share the existing water with animals as shallow well sites are not fenced. Persistent diarrhea and dysentery incidence during this period is 1 out of every 4 cases, and during the rains (from November to March) it drops to 1 out of every 10 cases. Outbreaks of shigella as well as cholera have been reported in the project area, especially in Gwembe District. There is also some resistance to antibiotics, which is why the MOH is recommending nalidixic acid. Unfortunately, there is no information available about the proportion of childhood mortality caused by persistent diarrhea, but based on district health workers reported experience most of the children presenting at the clinic are cases of simple diarrhea. Only 31.1% of the families in the target area have latrines. Seventy-three percent of the villagers draw water from a protected well while 25% obtain their water from rivers, 3% percent from a shallow wells,

6% from a hand dug shallow well and 5% have access to tap water.

4b.3 Knowledge and Practice

About three-quarters of the mothers gave the same amount or more fluids when their child had diarrhea: 80% gave the same amount or more breastmilk, 75.3% gave the same amount or more fluids, 70% gave the same amount or more foods. Ninety-one percent sought advice for their child's diarrhea: 6.8% at a hospital, 79.5% at a clinic, 8% with a CHW, 5.7% went to an herbalist and 2.3% went to the grandmother. The use of ORT was also relatively high at 88.6%, with 78% giving ORS sachets and the rest administering SSS, cereal-based or home available fluids. A significant proportion (12%) reported giving herbal medicine as well. Only 2% percent said that they used antibiotics. Many mothers in the area believe that the herbs greatly reduce the motility of the stools. A common herbal treatment given is guava leaves which are pounded and soaked in water and then given to the child to drink. Tomato leaves are also pounded into a paste and then put around the anal area. In reference to beliefs about what causes diarrhea, there is a belief that if a woman breastfeeds when she is pregnant the nursing child will have diarrhea. Another predominant belief in the area is that if a child passes by who is wearing a charm around his neck or waist then the mother who saw that child cannot breastfeed her own child or it will get diarrhea. The power of this belief manifests itself during growth monitoring as all mothers must remove their child's charm before weighing or other mothers will refuse to let their child be placed in those same weighing pants. Antidiarrheal medicines are available at the shop as well as flavored ORS, which although it is reported to taste much better is not necessarily affordable to all (ORS packets at the clinic and from CHWs are distributed free of charge).

When mothers were asked what actions should be taken when a child has diarrhea the following responses were given: proper mixing and administration of ORS (60%), seek medical help at a hospital or clinic (46%), don't know (6.4%), initiate fluids (5.9%), increase fluids (4.1%), small frequent feeds (7.4%), feed more in order to regain weight loss (0.4%), and give herbs (0.1). When mothers were asked what are important actions to take when a child is recovering from diarrhea, 27.8% said they didn't know, 68.5% said they would give more frequent feeds, and 5.9% said they would improve hygiene and follow up at clinic.

Health workers have set up ORT corners and distribute ORS packets for simple diarrhea. Health facility workers are following the current protocol based on the in-service training they have received (see below.) CHWs also have packets and distribute and demonstrate how to use them. Although flavored ORS is sold at the store, the shop owner does not provide any instructions for its administration and use.

4b.4 Approach

The project's approach will be to complement the health centers' management of diarrhea and dysentery cases with efforts to increase effective home management and prevention of diarrhea and referral of cases requiring medical treatment. This approach will include: community health education, strengthening of supervision and formation of additional CHWs, and promotion of diarrhea prevention messages while the water and sanitation activities are phased in with UNICEF.

The water teams efforts regarding use of latrines and hygiene practices are notable with good village participation centered around a water committee and the construction of latrines which serve as a demonstration.

The project will conduct focus groups to aid in designing messages and materials to: 1) promote appropriate home-based care and careseeking behaviors; 2) increase feeding during recovery; 3) explore the current beliefs regarding the causes of diarrhea. The project will work to ensure that consistent health messages, with emphasis on increasing fluid volume during acute episodes, are promoted at all levels including the health center, outreach activities, village and household. The district MOH has conducted inservice training regarding CDD based on the present protocol, with assessment and treatment charts posted in each center for quick referral. Planning will occur with the DHMT to ensure proper supervision and followup for effective implementation of the CDD protocol. The project will liaise with BASICS to see if health providers from the two districts can be included in the IMCI case management training and to access their IEC materials. CHW refresher training will be conducted for existing CHWs, and new CHWs (5 per year per district) will be formed to ensure improved access for outlying rural communities in order to reach high risk populations. With joint planning and outreach efforts, the project will work with the local health center to strengthen monthly supervision, maintain the supply of ORS packets, and review and collect community data. Quality case management, appropriate referrals, and reporting of suspected cases of dysentery to the local health center will be addressed during refresher training and during supervision visits. Neighborhood and water committees will also be trained in key diarrhea messages for prevention and home management and to identify signs requiring health facility treatment. Dialogue and training/exchange of ideas and practices will take place with local traditional healers as they are often consulted for episodes of diarrhea. There are no private providers in the project area.

4b.5 ORS

Zambia manufactures its own ORS packets. The MOH and UNICEF have a sufficient supply and the project will rely on the MOH 's on-going distribution system. These packets are available free of charge, however a curative consult costs 500 Kwacha (25cents). CHWs have bicycles and go to the health center for additional supplies when their stock runs low. TBAs currently are not allowed to distribute ORS packets. Health workers conduct demonstrations at health centers, outreach points, and ORT corners, and CHWs at the village level. During these demonstrations, workers use ORS packets and a common container found in the area, calling upon mothers to give return demonstrations as other participants look on. Workers ask questions to ensure not only understanding of mixing and preparation of ORT, but also of administering the fluid. When ORS is prescribed by the health worker, they counsel the mother in appropriate use of ORS and ask questions to ensure that she understands. The demonstrations, health worker probing, and health facility interviews with mothers at the Midterm Evaluation will provide a means to monitor mothers' skills in ORS preparation and use.

4b.6 Home Available Fluids

According to MOH recommendations, the project will promote home available fluids including:

sump soup (the base is maize with kernels removed and boiled in water until soft), cereal-based porridge (sorghum, maize, rice, millet), *Busika* (made from a wild fruit high in Vitamin C), sour milk *mabis* yoghurt, *chibwant* (also a sweet fruit drink), maize grits, and beverages made from roots. The project will not promote SSS as sugar is not a common household commodity.

4b.7 Health Education

The project will review and revise existing health messages and IEC materials related to diarrhea messages in collaboration with Regional Health Education unit and BASICS. Focus groups will be held to establish appropriate messages and further explore local beliefs and practices related to diarrhea. The project will also access BASICS IMCI materials. Once the messages and materials are developed, the project will train CHWs, TBAs, neighborhood committees, local leadership, traditional healers, women's development clubs and health facility workers in key diarrhea messages for home management. These groups will carry out health education sessions for mothers and caregivers at static posts, before all outreach activities and at village level through community providers and for school children. One-on-one counseling will be provided to mothers with children presenting with diarrhea. The project will monitor the quality of health education efforts by reviewing diarrhea incidence from clinic records on a monthly basis. Quality will also be assessed by observations of one on one counseling and health education sessions during supervision visits. Supervisors will also use observations as an opportunity to discuss what the mother has learned from this interaction and this information will help to determine how many contacts with health or community-based workers are needed. Workers will communicate with mothers using the participatory inductive teaching methodology which includes songs, drama, posters and return demonstrations. This method involves asking open-ended questions which draw out mothers' existing knowledge and then building on their knowledge. For ORT preparation, practical demonstrations will be used. Emphasis will be placed on signs and dangers of dehydration and the need for fluid replacement. Messages will include the following:

- initiate increased fluids early with the first loose stool, administering ½ cup every hour with cup and spoon or after every stool;
- continue or increase breastfeeding/feeding during the diarrhea episode;
- seek assistance from the health center if diarrhea persists for longer than 2 days or if there are any signs of severe illness or dehydration, such as: sunken eyes, dry mouth, thirst, poor skin turgor, low urine output, persistent vomiting, poor eating, drinking or breastfeeding, weakness, high fever, blood or mucus in stool, or passing watery stool every 1 - 2 hours;
- give the child extra food following the diarrhea episode to regain weight.

4b.8 Prevention

The project will concentrate mainly on appropriate careseeking and management of diarrhea in the home. The UNICEF-funded water program provides detailed health education in improving hygiene and sanitation such as: need for proper care and use of wells and latrines, proper disposal of stools, hand washing, benefits of clean drinking water, covering stored water, etc. This UNICEF project will also contribute to prevention through the establishment of additional protected water sources in areas without access to clean water. The establishment of a water committee for each

source will help ensure a sustained water supply and promote greater awareness of positive hygiene and sanitation practices. WV-Z will also be actively involved in promoting latrine construction by providing designs and instruction in building latrines. A separate nutrition program will also promote immediate and exclusive breastfeeding, appropriate weaning practices, and continued breastfeeding with no bottle feeding.

4b.9 Other Issues

All project staff have been trained in the diarrhea case management protocol. District MOH staff have received basic refresher training in diarrhea case management and CDD protocol charts are up on the walls at health centers, the CSP office and the district health office. Efforts will also be made to liaise with BASICS to ensure district representation in upcoming IMCI training to be conducted in Lusaka or Kitwe. Training in key health messages, effective health service delivery methods and refresher training in management of diarrhea will be provided for health facility workers over a 4 day period, delivered once a week for one month. Training for CHWs will occur over 3 consecutive days every 6 months regarding key health education messages, means of effective service delivery, and basic case management. New CHWs being formed will receive this training during their first year as a part of the 42 day course. Neighborhood committees will receive 3 days of training delivered over a 3 month period (one day per month) and focus will be on key education messages for home management and key signs for referral. Traditional healers will be targeted to participate in both the CHW and neighborhood committee training sessions and additional focus groups will be conducted to further explore their current diarrhea treatment practices and spheres of influence. Supervision for this intervention will occur according to the regular schedule (see Section E.3) and supervisors will use observations and a checklist to assess health and community health workers knowledge and case management practices. The Training Coordinator will supervise education being delivered. Outreach teams will supervise CHW activities.

D4.c Malaria

4c.1 Impact of Malaria in Community/Epidemiology/Project Objectives:

In order to impact the malaria associated morbidity and mortality in the project areas the following objectives will be targeted: 1) 10% increase in number of mothers who sought medical treatment for their child less than 24 months of age with fever in the past 2 weeks (baseline, 78%) and 2) 25% of households (3,600) in target area using impregnated bednets by the end of the project period (baseline estimate, 2%).

EHP reports that malaria is the number one cause of morbidity and the number two cause of mortality among all age groups. In the project area, the KPC data revealed a malaria incidence for children under 2 years of age during the previous two weeks of 41.5%, indicating a relatively high level of malaria. Reported malaria during pregnancy was even higher, at 57.1%. Health providers document the complaint/presence of fever and dose of chloroquine given on the antenatal card. Malaria is one of the top three reasons for clinic consults and hospital admissions in the districts. It is difficult to assess the prevalence of chronic or persistent malaria with anemia from clinic records, as the records only document the anemia without identifying the cause. Malaria along with

helminths and insufficient diet are the major contributors to anemia. Malaria incidence and associated morbidity and mortality are highest during the period of April to August, a few months following the rains as the temperature rises. Those villages located along Lake Kariba have the highest incidence of malaria as the climate and vegetation provide the perfect conditions for mosquito breeding. There is believed to be chloroquine resistant strains in the project area and convulsions are witnessed in children under five related to the high fevers experienced during periods of acute illness.

4c.2 MOH Policies and Availability of Drugs

MOH's protocol is used in the hospital and health centers and also includes the use of CHWs for the first line treatment of acute episodes of illness at the village level (see protocol in Annex M.) The protocol stipulates treatment based on age and weight by clinical symptoms: fever, vomiting, shivering, headaches, diarrhea (children). CHWs are trained to treat by symptoms, and to give the first level treatment (chloroquine tablets and syrup) on a age-based dosage. TBAs do not provide malaria prophylaxis or treatment. According to MOH protocol, no prophylaxis is provided during pregnancy due to fear of increasing chloroquine resistance in the area, but the policy supports prompt treatment for acute cases of malaria during the pregnancy period. The district health centers and hospital do sometimes run out of chloroquine supply as do the CHWs. Chloroquine is normally the only drug available at most health facilities. In the past Fansidar was only available through a physician's prescription but recently the MOH and the National Malaria Control Center (NMCC) decided to make Fansidar available at health centers and included it on the National Essential Drug List in order to deal with the high levels of chloroquine resistance. Quinine is restricted to clinical officers at the hospital, as are injectable chloroquine and quinine. The NMCC recently completed a systematic assessment of the efficacy of chloroquine with assistance from USAID, WHO, CDC, and the EHP. In May 1996, the results of the trials showed high levels of resistance to chloroquine. From 34% to 68% of *P. falciparum* strains were resistant to therapy; 28% to 46% of children required treatment with Fansidar during the trials because of an unacceptable parasite response to chloroquine.

At the health center the drugs are free of charge, but patients must pay a fee of 500 Kwacha (25 cents) for the curative consult. Since health centers often only supply chloroquine, individuals who react to the drug with itching often seek assistance and alternative treatments from traditional healers in order to avoid the unpleasant side effects. Clear instructions to patients regarding the importance of completing the full course are essential, as many prefer to save some of the medicine for the next episode of malaria. There are no pharmacies in the project area with the nearest pharmacy being in Monze which is 1 ½ to 2 hours by vehicle from the project site. Currently, Zambian shopkeepers do not follow the MOH protocol and routinely sell incomplete treatments as there is no followup and control regarding this practice. Pharmacies and shops do not require a prescription for the medicine, but sell treatments at the customer's demand.

In the project districts, ARI training has provided instruction regarding malaria/pneumonia overlap and providing chloroquine with antibiotic or just cotramoxizole alone if it is available. At times penicillin V is also used. With the IMCI training being conducted in the nation, there is potential

for additional training on this issue as some health workers follow the ARI training and others do not. There is an MOH policy which promotes the use and distribution of impregnated bed nets but resources are limited to implement this on a nationwide scale. The MOH policy also supports the district council in providing insecticide spraying (lasts 3 to 6 months) for households in the community at a cost of 500 Kwacha per room which is out of the reach of most villagers.

4c.3 Knowledge & Practice

Among the 41.5% of children under two years of age that had malaria in the last two weeks, 82.1% of their mothers sought treatment. The majority of these mothers sought treatment at hospitals (16%), clinics (62%), from CHWs (14%), and the pharmacy (5%). Mothers also reported high utilization of the health system for malaria when they were pregnant. Among the 57.1% of the mothers reporting that they had malaria during their last pregnancy: 17.5% went to the hospital, 70.1% went to the clinic, and 9.5% went to CHW for treatment. Traditional healers and herbalists were only mentioned in five percent of the cases and the traditional term for malaria is not used. It appears that traditional medicine is not the first line of treatment for malaria, which is probably related to their understanding of the etiology of malaria, believing that it is transmitted by the mosquito. The target population tries to prevent malaria by burning mangoes leaves in the house during the evening so that the smoke drives the mosquitos away. There is some sale of mosquito nets currently in the markets in Sinazongwe, however many villagers sleep outside their huts due to the heat and require instruction on how the net might be supported outside the house.

There is low compliance with the malaria treatment prescribed. Often individuals (particularly adults and pregnant women) begin treatment but then save the following days' dosages for their next episode. There is better reported compliance for children except when chloroquine syrup is in short supply and tablets must be crushed and given to the child. The bad taste of the tablets makes administration very difficult. More information for household/community malaria management is needed and the project plans to conduct focus groups regarding malaria treatment to determine the following information:

- 1) what do they do when anti-malarial drugs are not available?
- 2) what do they do when the fever does not respond to treatment?
- 3) are drugs accessible?
- 4) is there transport to a referral center?
- 5) what is their knowledge, practice, and beliefs regarding malaria treatment and completion of the course prescribed?
- 6) what home or traditional treatments do they give to children and adults?
- 7) supportive factors and obstacles to bed net use (i.e. ability and willingness to pay, how homes are set up, etc.);
- 8) beliefs about malaria during pregnancy and treatment sought;
- 9) acceptability of appropriate course of treatment.

This information will be used to establish and target appropriate messages and IEC materials, as well as select the most appropriate avenues for increasing access to treatment and encouraging the use and sale of bednets.

4c.4 Approach to Case Management

The project will support the DHMT which already has a work plan to improve case management at health facilities and will provide additional emphasis on key health messages such as importance of completing treatment to avoid development of resistance, and strategic screening and followup for high risk groups for complications, specifically children under five and pregnant women during their first pregnancy. The DHMT will be supported and mobilized through joint planning and outreach efforts to ensure proper training, drug supply and supervision support for CHWs working at the community level. The MOH malaria protocol is followed in the district services and through the CHW management of malaria at the village level. The project will seek to improve careseeking behaviors of mothers and caregivers, focusing on prompt seeking and referral for complicated cases, and prevention practices by delivering key health messages at the health facility, during outreach activities, and at the village level through health staff, community providers and health committees, local leadership and traditional healers. Midwives and TBAs will be instructed in the importance of referral for treatment of acute attacks of malaria during pregnancy and potential complications (low birth weight, premature deliveries, and anemia) as prophylaxis is not part of MOH protocol (issues of supply and resistance).⁴ Fixed antenatal and outreach clinics will provide treatment for pregnant women with malaria. There are currently no shops or pharmacies selling chloroquine treatments operating in the area.

The project will work closely with the MOH Southern Regional health education unit and BASICs (IMCI materials) project for the refinement of IEC messages and staff training. Focus groups will be carried out to design the messages needed. Health education sessions for mothers and caregivers will be carried out health facilities during EPI and antenatal clinics, before outreach sessions, and at the village level through community providers and school children. A participatory approach building on what people already know will be used and posters, dramas, songs with time for questions and answers.

The project will also liaise closely with MOH and UNICEF to track morbidity/mortality patterns according to sex/age groups, seasonal and zonal variations as well as incidence of cerebral malaria.

4c.5 Appropriateness of Bednets in the Prevention of Malaria

The malaria vector in Gwembe Valley is the *Anopheles gambia* which predominately bites in the evening and at night. In the warm season, there is more exposure to mosquitos as villagers tend to sleep outside due to the heat. Malaria transmission occurs throughout the year, but is highest from April to August. For those villages living along Lake Kariba, breeding sites are abundant and exposure to the mosquito vector is high. The MOH policy supports and encourages the use of impregnated bednets and has ongoing initiatives in various parts of the country with support from UNICEF. In Sinazongwe District, the MOH has been selling nets for the past 3 months and the nets are very well accepted in the area, especially with communities along the lake's edge.

⁴ TBAs will refer women for treatment since per MOH policy they are not currently allowed to treat malaria.

4c.6 *Implementation and sustainability*

The project will collaborate with MOH, UNICEF, and the Tropical Disease Research Center in Lusaka (TDRC) regarding net and chemical procurement as they have been doing this in other areas of the country. Currently, the nets are being purchased by UNICEF in Tanzania and are being sold for 7000 Kwacha each (\$4). IGA groups will be set up for the sewing, marketing and selling of the nets, as it is cheaper to buy the mosquito net material in bulk and have them made to order. Several family members usually sleep under one net. Training of IGA groups regarding promotion and marketing, redipping and proper disposal of chemicals, and business management will be carried out. Technical assistance from UNICEF will be sought regarding the type of insecticide, dosage and frequency of redipping to use. Supervision of IGAs and community visits will take place to ensure 6 month redipping of nets. With the sale of bednets, training on deploying the nets both inside and outside the home and education regarding proper care of the net are critical. Distribution during periods of the year where vector exposure is high will aid in enhancing the perceived value of the nets.

4c.7 *Acceptability and Feasibility*

The sale of nets in Sinazongwe began three months ago and seems to be acceptable to the people, particularly those who live along the lake. The greatest constraint for villagers is the cost of the net, as some households have very little purchasing power. Another issue is that the nets are currently being sold from the district hospital which is not very accessible to rural villages. The project will work closely with the DHMT and UNICEF to establish local production and sale of bednets and ensure that activities are complementary. The project's promotion of bednets will make nets more accessible at the community level and will also extend availability to Gwembe Valley. Local production will enhance sustainability of the nets and will provide for net maintenance at the community level. IEC will be used to generate further demand for the nets through many established community channels: CHWs, TBAs, clinic workers, neighborhood committees, and village and church leaders. These groups will promote the benefits of using nets for prevention of malaria and a more restful night's sleep and will demonstrate the appropriate use of the nets. The project will emphasize messages promoting behaviors which decrease human contact with mosquitos, i.e. cutting weeds and brush around the house, using mango leaves for burning, and covering children at night.

4c.8 *Other Issues*

Linkages with BASICs will ensure that district health staff (health center workers) are represented and participating in IMCI training, with focus on following protocol and malaria and pneumonia overlap. Three hours of refresher training in malaria treatment and prevention will be provided for district and project health staff, and an initial 3-6 hours of training will be provided for CHWs, neighborhood committees and other community providers. Messages will include issues related to careseeking, management and prevention, with followup being provided by the Training Coordinator. Every year additional CHWs will be formed and trained for each district. CHWs will receive oversight and supervision every month at which time supplies will be restocked and records reviewed jointly and collected. Quality will be ensured through health facility surveys conducted on a yearly basis, which will examine appropriateness of treatment provided in relation to symptoms

presented, drug and dosage administered and counseling provided. BASICS recently brought in a consultant, Dr. Gil Burnham, to assist the MOH in developing quality of service evaluation tools for facilities. These tools have been tested on services near the nation's capitol, and the project will work with BASICS to adapt them for use in the Valley.

D.4d Maternal and Newborn Care

4d.1 Objectives

In order to impact maternal mortality, the project will seek to: 1) increase the number of women who can state at least 3 danger signs during the antenatal period and labor which require immediate assistance from a health professional from a baseline rate of 30% to 60% by the end of the project; 2) increase the coverage of mothers receiving two doses of TT before the birth of their youngest child less than 24 months of age from the baseline rate of 63% to 83%; 3) establish a village level referral transport support system through existing neighborhood committees.⁵

4d.2 Baseline Information

The MMR in Zambia is 202 per 100,000 live births (UNICEF "State of the World's Children", 1994). The major underlying causes of maternal mortality are:

- young age at first pregnancy (17.9 years)
- too closely spaced pregnancies
- lack of knowledge about high risk pregnancies and deliveries on the part of both service providers and users
- high number of deliveries supervised by untrained personnel
- poorly equipped health facilities
- poor referral systems
- the use of traditional herbs during labor

The leading causes of morbidity and mortality among women in Zambia are:

- anemia
- sexually transmitted diseases including HIV infection (HIV positivity among antenatal mothers - 25%)
- toxemia
- hypertension
- malaria
- complications of pregnancy and delivery

There are no specific maternal mortality measures for the Gwembe and Sinazongwe Districts and although access to prenatal care is high (with the assistance of outreach teams), the access to medical assistance during labor and delivery is very minimal and the ability to handle obstetrical emergencies

⁵The project will also try to raise other funds to upgrade at least 1 facility per district to deal with obstetrical emergencies.

is virtually non-existent. The baseline KPC survey completed in February, 1997 showed the following:

Antenatal Care: 80% of the mothers had received at least one antenatal visit during their last pregnancy, while 67% had made three or more visits; 96.3% of the mothers knew that a pregnant woman should start prenatal care before the third trimester, with 69% of these stating that a woman should start prenatal care during the 1st trimester;

Tetanux Toxoid: TT2 coverage was measured at 63.7%; 68.5% of the mothers stated that 2 or more injections are needed before the birth of the child but only 27% of the mothers knew that TT protects both the mother and the child.

Danger Signs: Knowledge regarding dangers signs requiring assistance during pregnancy was low as follows: 42% mentioned bleeding, 9% said decreased fetal movements, 11% said swelling of the hands or feet, 27% mentioned headaches, 42% stated early contractions, 2% urinary problems, and 15% discharge of fluids.

Delivery Assistance: Women were most likely to be assisted with their births by a family member (55%). Seventeen percent of the mothers delivered at a hospital or clinic assisted by a doctor or midwife, while 11% of mothers had no assistance, 12% delivered with the help of a TBA and 4.8% assisted by neighbors (4.8%).

Referral resources: If a woman experiences difficulties during labor and delivery, she must be transported to one of two facilities depending on whether she was in Gwembe (300km) or Sinazongwe (200km) districts. The referral facility used for the Gwembe District, which can perform cesarian section and blood transfusions is 300 km away from the center of the district; for Sinazongwe the referral site is 200km away. In other words, neither district has a referral center for handling obstetrical emergencies within their district borders, but must use sites located outside the districts. If a woman is delivering in a health center and encounters complications which require referral, the health center ambulance must be called and the referral site notified. It can take anywhere from 1 to 3 hours for the ambulance to arrive (the ambulance must perform several tasks for the health center). If a woman is delivering at home, she must first be transported from the village to the local health center by oxcart until reaching a major road where a truck which serves as public transport can be used.

Transport: The time required for a woman to travel from her home to the nearest health center ranges from 1 to 3 hours (not including the hour required to find an oxcart or a truck on the main road) and the time required to travel from the health center to the referral site ranges from 1½ to 3 hours (not including the additional 1 - 2 hours required to locate an ambulance or alternative form of vehicle transport).

In summary, for a woman delivering at home encountering complications it can take from 6-12 hours to reach a referral site which can provide "essential obstetric care"; and for the woman delivering at a health center, the time required to reach the referral site could range from 3 to 8 hours. The KPC team encountered two obstetrical emergencies in the villages which provided concrete examples of the severe transport and facility capacity problems surrounding the management of women encountering obstetrical emergencies and requiring assistance. (See attached KPC Survey Report for details, section

4d.3 Prenatal Care

Gwembe District has one hospital and 3 rural health centers where prenatal services are available and Sinazongwe has one central health center and 11 rural health centers which provide prenatal care. Prenatal care is also provided as a part of the districts' outreach activities with 32 health delivery points in Gwembe and 35 in Sinazongwe. The project is assisting the DHMT to serve half of these outreach points and to supervise half of the TBAs. Each community located at a distance greater than 12 km from the nearest health facility receives one visit per month for the delivery of basic services. TBAs work with the midwives/nurses during outreach activities offered from the delivery points, with 52 TBAs actively functioning in Gwembe district and 56 TBAs functioning in Sinazongwe district.

Prenatal care services are considered to be of "good quality" and are viewed as being useful as long as access (in this case determined by distance since services are free of charge) is possible. KPC data regarding the proportion of women receiving prenatal care during their last pregnancy confirms this. Services provided during prenatal consults include:

- estimation of gestational age using measurement with fingers in relation to mother's "belly button"
- auscultating fetal heart tones with fetoscope
- checking weight of mother with stand-up scale
- measuring of blood pressure
- questioning mother about presence of complications and documenting on antenatal card
- provision of TT injections with goal of two doses to be provided before delivery and five doses for protection for a lifetime
- malaria treatment with chloroquine for mothers experiencing acute episodes of malaria
- iron/folic acid supplementation with monthly supply provided for daily tablet intake
- health education covering topics of hygiene, preparation for home delivery, care of newborn, and importance of maternal nutrition and breastfeeding
- screening for STDs, UTIs and unusual/bad smelling drainage or discharge.

4d.4 Delivery/Emergency Care

The intrapartum delivery care facilities for the districts are as follows: Gwembe district has 2 health centers with delivery rooms, waiting rooms and midwives to assist with the delivery process. If there is a high risk pregnancy, the woman is transferred to the District hospital and if there is an obstetrical emergency, the patient is transferred to the nearest facility outside the district where essential obstetric care can be provided. In Sinazongwe district, there are nine health centers with delivery rooms and waiting areas and the centers are staffed with midwives to assist. Women developing obstetrical emergencies must be transferred to a referral site outside the district where essential obstetric care can be provided. The quality of care for labor assistance for uncomplicated deliveries is good (complicated deliveries cannot be easily managed due to lack of supplies and equipment and staff trained in performing c-sections, etc.) and the main constraint for low usage is due to the distance which communities must travel to reach the centers. Each district has one ambulance which can provide transport for referral cases. However, the ambulances are multipurpose and are very busy, making it difficult for them to get out to the rural areas to pick up

patients. There are also times when the ambulances do not run because there is no fuel.

4.d.5. *Postpartum Care*

Postpartum services are very underutilized and this is consistent with the national average of only 7.3% coverage for this service. The main reason for low usage is that mothers often do not see the need or value of this service unless a problem or complication arises in the postpartum period. Health centers, outreach teams working from the health delivery points and TBAs are providers of these consults. Postpartum care from the health centers and during outreach activities performed by midwives includes counseling and encouragement in exclusive breastfeeding, assessment for presence of infections, and provision of vaccines for the newborn. Currently, family planning services are not seen as an integrated part of the postpartum consult.

4d.6. *Constraints*

The constraints to prenatal, delivery and postpartum care in the project area are as follows:

- *Prenatal care* is constrained by lack of specific health education regarding the danger signs during pregnancy which require immediate referral and emphasis on developing a birth plan with the mother so that she is prepared for her delivery (clean instrument to cut the cord, etc.) irrespective of the location where she chooses to deliver.
- The main constraints to *delivery assistance* are the long distance villagers must travel from their homes to reach the health centers, and the distance which must be traveled to reach the referral site for essential obstetric care.
- An additional constraint to delivery assistance is that the TBAs are not well trained in life saving skills and some midwives require refresher training in life saving skills.
- In relation to *postpartum care*, the constraints include a lack of knowledge both among service providers and mothers regarding the importance of postpartum consult to ensure and encourage exclusive breastfeeding, address issues of child spacing and plan for use of a modern contraceptive, as well as time constraints of service providers to properly dedicate time to this activity as they are overworked and very busy.

4d.7 *Maternal Care Providers and Birth Attendants*

Birth attendants as measured by the baseline KPC survey are as follows:

- 55%, family member;
- 17.1%, hospital or health center midwife;
- 11.5%, trained TBA;

- 11%, the mother herself;
- 4.8%, neighbor or second wife.

52 TBAs are working in Gwembe district and 56 in Sinazongwe with the average number of deliveries per year per TBA being 8 - 10, with additional time spent in assisting with the provision of prenatal care, mobilizing the community, and health education, especially working with the outreach teams from the health delivery points. Until last year, the district MOH trained 10 new TBAs per district per year, but currently there is a hold on the further training of TBAs until the

initiative can be fully evaluated to justify the effectiveness of resources invested. The dropout rate in the 2 targeted districts for TBAs is low, with only 2 TBAs being replaced over the past 3 years. In both cases, the women had died due to illness. TBAs have been effectively motivated with incentives, including a bicycle increasing mobility for work, a lamp for deliveries at night and a delivery kit which is replenished by the local health center.

The “Gold Standards for Maternal Care” as well as UNICEF’s Safe Motherhood/Lusaka Unit will be used as references and key resources in the training of midwives conducting prenatal and post partum consults as well as those providing delivery assistance. The groups to be targeted for training include:

Training Participants	Training Topics
Health workers, TBAs, community leaders, neighborhood committees, CHWs, other women leaders	Key maternal care issues, danger signs requiring immediate assistance, referral messages
Nurses/midwives serving at health centers and with outreach activities	Providing supervision for TBAs, CHWs, and neighborhood committees; preparing for and receiving referral patients showing problems during pregnancy, labor and delivery. Refresher course on quality prenatal/postpartum and delivery assistance care
Village headmen, leaders, churches, neighborhood committees and community providers	Purpose, benefit, and necessary support for emergency referral transport system for obstetrical emergencies
Neighborhood committees	Establishment of a village-supported referral transport system
Mothers, caregivers, and leaders	Health education regarding maternal care, importance of prenatal and postpartum consults, importance and purpose of TT vaccine, birth plan, maternal nutrition, care of the newborn, early/exclusive/continued breastfeeding, danger signs with immediate referral, child spacing/use of modern contraceptives, management of acute illnesses during pregnancy, etc.

* Training of additional TBAs for the districts will not be planned at this time until the MOH comes to a decision regarding the role of TBAs in the health care delivery structure.

4d.8 Prenatal Care

In relation to prenatal care, current coverage in the district is quite high with 80% of mothers having at least one prenatal consult during their last pregnancy, with 66% of these having three or more. Efforts will be placed on increasing the effectiveness of health education provided during prenatal care, as current knowledge regarding danger signs during pregnancy, the purpose of tetanus vaccine and number of doses required is very low. Also, education efforts regarding early and exclusive breastfeeding, preparation of a birth plan, and the importance of child spacing all require strengthening. Prenatal care will continue to be provided from the health centers and from the

outreach health delivery points (32 in Gwembe and 35 in Sinazongwe - each visited once a month). Prenatal care will be provided by health center midwives and the project will provide an additional 2 midwives (one per district) who will assist the district midwives with coverage for half of the outreach points. The outreach activities will be planned on a monthly basis with the DHMT. The outreach teams will be accompanied by the CHWs and TBAs who will do the community mobilization and village site health education. Expectant mothers will be encouraged to make at least 3 prenatal visits beginning in the first trimester of the pregnancy. Consults will include:

- blood pressure check
- monitoring of weight gain
- assessment of gestational age (measuring with fingers in relation to “belly button”)
- assessment of fetal presentation
- planning for delivery at site where assistance can be provided if abnormal presentation is expected
- assess for presence of any infections (particularly STDs) or acute illnesses requiring treatment, with treatment provided or referral made if necessary
- auscultation of fetal heart tones
- screening for edema and others signs of toxemia
- screening for others signs of high risk or danger
- iron supplementation
- tetanus vaccine provision with at least 2 doses being provided before the birth of the child
- health education regarding maternal nutrition and care, danger signs during pregnancy, development of a birth plan, care of the newborn, early/exclusive breastfeeding, benefits of child spacing, etc.

Treatment for acute attacks of malaria especially for mothers during their first pregnancy will be emphasized as malaria incidence during pregnancy is high (KPC baseline survey - 57% of mothers reported malaria episode during their last pregnancy) and prophylaxis is not part of the MOH policy.

Health education for mothers, caregivers and community members will be delivered by health workers at health centers and with outreach activities during antenatal consults and by community providers (CHWs, TBAs, neighborhood committees) at the village level. Existing maternal care messages will be reviewed in collaboration with regional health education unit and UNICEF/Safe Motherhood unit to produce new or strengthen existing messages. Focus groups will be conducted with mothers, grandmothers and traditional healers regarding traditional herbs used during the prenatal period for inducing labor. Messages will be communicated using the participatory inductive teaching method with use of posters, songs, and drama. Education messages to be delivered during antenatal care and at village level include:

- contacting health provider early in pregnancy for prenatal care;
- nutritional care with emphasis on adequate weight gain and the need to eat iron-rich foods;
- the need to seek prompt treatment for malaria attacks;
- value of iron and folic acid supplementation;
- purpose and number of tetanus toxoid immunizations required;
- recognition of danger signs and need to seek care at closest health center including the following signs:

- vaginal bleeding
- excessive tiredness or paleness
- swollen hands, face or ankles
- headaches
- fever
- vulval sores
- any STD symptoms
- painful urination
- passing fluids other than urine
- labor pains longer than 12 hours without progress ;
- birth plan to ensure clean hygienic delivery with trained attendant if possible;
- knowledge of referral systems and plan for emergency transport to referral site if emergencies arise;
- importance of breastfeeding the baby within the first hour after birth and giving colostrum, and importance of exclusive breastfeeding for the first 4 - 6 months of life;
- delivery practices, namely: immediate warming and drying; stimulating baby to cry, ensuring airway is clear; using the “kangaroo method”; clean cutting and care of the umbilical cord;
- planning for future pregnancies, the need for adequate child spacing and the role of contraceptives.

4d.9 *Delivery and Newborn Care*

The project will not be training personnel to deliver babies, but will focus on health education on detection of danger signs and the establishment of a village-level referral transport system for obstetrical complications/emergencies through neighborhood committees. During antenatal consults, mothers will be encouraged to have a plan and prepare for a safe and clean delivery. Young pregnant women (< 15 years), older pregnant women (> 35 years), multiparous women (> 5 pregnancies), women with previous c-sections or problems with past deliveries, women with preexisting medical conditions, women of short stature (<150cm), etc. will be closely followed through prenatal care and encouraged to make plans to deliver with a trained attendant. CHWs, TBAs, village leaders, and neighborhood committees will be provided instruction which will help them identify women showing signs which require immediate referral. The training of additional TBAs will be placed on hold until the MOH determines its policy regarding the role of these community service providers as the TBA program is currently undergoing an evaluation. Existing TBAs will be supervised on a monthly basis by the outreach teams covering their service areas. The supervision activities will provide a format for additional training and strengthening of skills as well as an opportunity to review community-based data and its implications for program interventions.

Women planning to deliver at home will be instructed to seek immediate assistance if there is an excessive loss of blood, convulsions, fever and chills, or no progress after 12 hours of labor. For care of the newborn, mothers planning to deliver at home will be instructed to clear mucus from newborn's mouth and nose to stimulate the infant to cry, to dry, warm and cover the infant and to immediately (within 1st hour) place infant on the breast. The quality of services for assistance with normal deliveries at the local health centers is considered to be high with the district MOH

providing refresher training in delivery assistance, criteria and process for referrals, and immediate care of the newborn and mother after delivery (for example massage of the fundus to control bleeding; ensuring delivered placenta is complete, etc.).

4d.10 *Emergency Obstetric Care*

Currently there is not a referral site in the project area which can provide the essentials of obstetric care. This project does not have sufficient resources to upgrade any of the existing facilities within the two districts, but the WV-Z management team will be looking for donors who could provide resources to purchase supplies and equipment and train district staff to establish at least one referral site within each district which could provide essential obstetric care. At the same time, the project will work with the DHMT to facilitate the establishment of a village level referral transport support system through the neighborhood committee structures. Staff from the local health center and the outreach team will dialogue with village headmen, leaders, churches, neighborhood committees and community providers (CHWs, TBAs) regarding the purpose, benefits, and support required for the establishment of an emergency referral transport system for obstetrical and other medical emergencies arising among their village populations. Village leaders, neighborhood committees, community providers and members will be instructed by health center and outreach team staff regarding signs/criteria of obstetrical emergencies which require immediate attention and referral to the health center site. Together a plan for dealing with an emergency will be created which will identify:

- when emergency transport will be used
- who will be notified
- how transport will be arranged and by whom
- how much time will be required for transport and how this time will be minimized
- how transport will be paid for
- who will travel with the patient

Outreach staff will meet with the neighborhood committee on a monthly basis to provide guidance and support for the establishment of the village supported referral transport system. Community leaders and providers and neighborhood committee members will be taken to health center and referral sites to meet clinic staff and view what services are available.

4d.11 *Postpartum Care*

The project will support the DHMT with joint planning for outreach activities and the provision of 1 additional midwife who will assist with the provision of postpartum care through the outreach services. The CHWs and TBAs will assist with mobilizing and following up with village women requiring postpartum consults. Presently, women are encouraged to come for postpartum consults within two weeks of delivery or sooner if any complications arise. Postpartum consults provided from the health center and with outreach activities will provide opportunities to assess infant's weight, enroll infant in immunization program, assess mother for infection or anemia/blood loss, identify problems with breastfeeding, monitor healing of tears/episiotomy, and provide treatment for any other problems identified as well as to provide counseling regarding hygiene, nutritional needs, exclusive breastfeeding, infant's immunization schedule, and child spacing services.

4d.12 Documentation

A copy of the antenatal card is attached in Annex I. If a mother loses her card, a new card is started indicating the number of previous visits. Currently, at health centers and with outreach activities, the DHMT is collecting information regarding first time prenatal and postpartum attenders and reattenders, number of TT injections provided according to dose, total number of deliveries assisted, total live births, number of live births which were <2.5kg, number of still births, number of neonatal deaths and number of abortions. TBAs are submitting the same monthly data to the local health center supervisor, in addition to the number of mothers referred to the health center, the sex of the newborns and the number of normal deliveries.

D.4.e Family Planning

The family planning objective which is to be completed by the end of the project period is a 20% increase of mothers of children less than 24 months of age who desire no more children in the next two years or who are not sure, who are using a modern contraceptive method. (Baseline measurement: 9.8%)

4e.1 Baseline Information

The total fertility rate for the nation is 6.5, and 7.1 for rural areas. The current level of modern contraceptive use in the project area based on KPC survey results is 9.8%. Of the mothers reportedly using modern contraceptives the majority were taking the pill (84%), followed by condoms (16%). Other forms of avoiding pregnancy which mothers reported using included lactation amenorrhea (2 mothers), the rhythm method and withdrawal. At the time of the survey, 28 mothers with children less than 2 years of age reported they were pregnant. These represent a group of 10% who are closely spacing their pregnancies, as opposed to waiting at least 2 years between pregnancies to allow for proper care and breastfeeding of the infant and to allow their own bodies to replenish their stores. An additional 17.7% (48 mothers) of the mothers with a child less than 2 years of age said they wanted a child within the next two years. Mothers with an immediate demand for contraceptive services who are **not** currently using a method, are not pregnant and do not want a child in the next two years, represented 65% of the group of potential users, thus indicating a significant unmet demand. It is important to note that with polygamy practiced among the Tonga people, there tends to be competition among the wives to produce children. However, the presence of polygamy could serve as a benefit for child spacing, as the wives could potentially rotate their births and fulfill their need for rest.

The project area can still benefit from health education regarding child spacing, as the predominant belief is that a man's strength is related to his wife's ability to produce children. Fertility in this culture is very important and a woman who is infertile is usually divorced and considered bewitched by her family. Young girls at the age of 12 to 13 (first menstrual cycle) are kept in their homes for 3 to 4 months (prohibited to go outside) as part of an initiation practice into womanhood at which time it is believed that they are being groomed, trained and "fattened up" in preparation for marriage and childbearing. If a woman is unable to bear children, it is also believed that her initiation process was not performed properly. Some of the villagers are also influenced by the teachings of their local churches, which do not always encourage family planning. To date, men have not been targeted for

health education regarding family planning services and it is vital that a woman has the blessing of her husband before she uses contraception.

Quality of family planning services is not an issue as much as basic access to any family planning services, since the majority of the families are located at distances beyond 12 km from the nearest health center. The counseling provided for methods is average and the number of methods offered are very limited, with commonly only one method and at the most two offered--the pill (always), IUD (sometimes) or the condom.

4e.2 *Current Family Planning Services and Constraints*

The MOH does have goals and standards for family planning services and has identified several areas of weakness in the delivery of services which they are attempting to address, but will require much assistance in rural areas where reproductive health issues are more sensitive and there are greater logistical constraints. Areas targeted for improvement include: making more than one method of modern contraceptive available with services; improving quality of care through improved counseling and encouraging partners to make consults together; consistency in type of oral pill provided as brands vary depending on the donor and mothers must readjust to new brands as stocks are limited; and increasing access by reducing the distance required to travel for family planning services. The MOH has shown its commitment to increasing access to family planning services by approving the initiation of community-based distribution of contraceptives through volunteer "CBD agents", an initiative which is being facilitated through the JSI Family Services Project in collaboration with both the MOH and NGOs working within Zambia. They have also designed the FP Services Monthly Activity Record for each district (see Annex N.)

Currently, district midwives and nurses provide family planning from the health center and during outreach activities. In Gwembe district, there is one hospital and 3 rural health centers which provide family planning consults in addition to the monthly visits of the outreach team to the health delivery points. In Sinazongwe district, there are 7 rural health centers in addition to the activities of the outreach team which provide family planning services. At the centers, there is inadequate space for storage of contraceptives and private and comfortable consults. The services are offered in a multipurpose room and supplies are kept in a box in the corner. IUDs are difficult to obtain and Depoprovera is rarely offered as most nurses do not view it as a viable option since it was banned years earlier (and later was reapproved.) However, oral contraceptive (although the brands change regularly) and condom supplies are adequate for the current demand. Tubal ligations can be performed in Monze hospital for medical purposes only, but are also performed as a contraceptive method at the referral site in Choma which is outside the project area. The Planned Parenthood Association of Zambia has been assisting the MOH at the national level with IEC activities related to child spacing and with contraceptive supply and distribution, and currently has a branch office in Sinazongwe district. Contraceptive supplies are in the medical store in Lusaka and are released to the districts as their activity reports are received and requisitions are submitted.

The constraints to family planning in the project area include:

- obtaining a varied supply of contraceptive methods;
- maintaining an adequate supply of contraceptives to respond to the expected increased demand resulting from health education and increased access to services through the CBD initiatives;
- addressing prevailing beliefs regarding fertility. This subject is still considered private, and some churches discourage the use of contraception. Therefore creative approaches to involving men as the decision makers in the household will have to be developed, and trusting relationships with community/church leaders and community members will have to be established in order to sensitively initiate and encourage dialogue on the issue;
- current access to services is poor as many villagers are located at great distances from the health centers. The proposed CBD initiative will require solid, consistent training and follow-up supervision from the local health center and outreach team to be effective at the village level;
- the quality of counseling offered to women during consults could be improved. Health providers will require additional training to improve these skills.

4e.3 Approach

The project will assist with the promotion of child spacing messages in order to increase mothers' and fathers' knowledge regarding the benefits of child spacing and the services available. The project in collaboration with the MCH unit will review and revise key child spacing messages and IEC materials to be used in the district. The regional health unit and JSI FSP will be contacted for assistance regarding key messages. Focus groups will be conducted with village men and women regarding sexuality, reproductive health, perceptions and current understanding of child spacing and the services available. The understanding gained from the focus group dialogue will be used to better tailor health messages for the project area. Midwives, district health staff, TBAs, CHWs, neighborhood committees, community and church leaders will be trained in the key child spacing messages and on the services available in the area. Health education sessions for men and women at the village level, health center, and during outreach activities and through collaborating churches will be conducted on the benefits of child spacing, methods available and availability of services. Emphasis will also be placed on introducing the subject of child spacing to mothers during prenatal and postpartum consults. There are currently no groups for men to discuss issues of child spacing and HIV/AIDS issues, and the project will stimulate formation of these groups, for example, through church and village leaders.

In order to address the quality of existing services being provided at the health centers and with outreach activities, a training curriculum will be developed and refresher training will be given for midwives and nurses delivering these services by the Training Coordinator in collaboration with the Regional MCH Supervisor. Training will take place during monthly 5-hour sessions for 3 months. Training content will focus on counseling skills, types and specific characteristics of each method, follow-up for drop outs, and issues of STD prevention if mothers choose a non-barrier method. To improve the variety available, the project will coordinate with the district and regional MCH unit

to procure contraceptives from the Lusaka unit, and will also discuss options with Planned Parenthood.

To address issues of access to family planning services, the Training Coordinator will collaborate with the district MOH, Regional Supervisor and MCH district department for the training, supervision, and supplies for CBD agents. The goal is to train 15 CBD agents per district focusing on reaching communities located at distances greater than 15km from the nearest health center. Two project staff underwent training for the TOT of CBD agents and initiatives in December 1996 as part of a JSI FSP initiative. Feedback regarding the training was excellent and JSI is currently working with DHMT and project staff on the development of a proposed plan of action for the training of CBD agents within the district and has offered to provide guidance and resources for this activity. The CBD supervisors are the midwives serving on the outreach team who provide family planning services. These midwives will provide monthly site supervision to the CBD agents, replenishing their supplies, reviewing data collected and discussing successes and constraints encountered. CBDs will supply oral contraceptives and condoms, and will refer for other methods to the outreach team or health center depending on the location of the community

The DHMT is currently collecting the following family planning services data from health centers and outreach teams:

- new acceptors
- continuing acceptors
- number of total attendances
- number of contraceptives distributed according to type of method
- remaining stock, with this data being used for the ordering and restocking of supplies.

The MOH team will participate in monthly planning meetings with project staff to review the FP data, giving attention to the types of methods being accepted and numbers of new attenders and continuing users.

D.4f HIV/AIDS

The HIV/AIDS objectives to be achieved by the end of the project period are: 1) Provide support to district HIV/AIDS Coordinator for implementation of annual plan with specific targeting for the formation and strengthening of Anti-AIDS clubs and workshops for health workers, community leaders and other groups regarding key issues related to HIV/AIDS in the project districts; 2) 30% increase in mother's knowledge regarding protection of oneself and partner against HIV/AIDS (baseline: 55%) and 3) 85% of fathers in target area know how to protect themselves and their partners against HIV/AIDS (No baseline.)

4f.1 Baseline Information

The national estimates for HIV infection are one out of every four people in urban areas and one out of every 10 to 13 for rural zones. In 1994, hospital data for Gwembe Valley showed that 37% of blood donors tested positive for HIV. For 1994, the MOH Southern Province data revealed that hospital deaths for AIDS-related-complex for 0 - 14 year olds was 1.6%; for 15 years and older,

6.6%; and for adults, hospital deaths related to pulmonary tuberculosis were 25.2%. Opportunistic infections related to AIDS in the area are predominately pulmonary tuberculosis, chronic diarrheas and chronic pneumonia.

AIDS is recognized as a disease although many villagers in the rural areas do not link opportunistic infections such as tuberculosis with AIDS. Unexplained weight loss or "slim's disease" is associated with AIDS. The KPC baseline survey revealed that 99.6% of the mothers interviewed had heard of AIDS, with the majority obtaining their information from neighbors (48.3%), followed by health workers (30.5%), radio (15.2%), and a small percent from knowing an AIDS patient (2%). Mothers' knowledge regarding specific modes of HIV transmission was high, as follows: those who know the virus can be contracted through sexual intercourse - 97%, sex without a condom - 87.4%, from having many sexual partners - 97.8%, from sex with their husband - 84.4%, from the pregnant mother to her fetus - 87.4%, from blood transfusions - 1.5%, from infected needle - 4.4%, from tattoos/scarification - 74.3%. Mothers also stated several "myths" regarding HIV transmission as follows: 19.7% said HIV infection can be gotten from eating with an infected person; 48.7% said it can be obtained through an insect bite; 30.9% said a person could be infected through kissing; and 17.5% said it was possible to get the virus through handshaking. 4.1% of the mothers said they believed AIDS can be cured, 93.3% said there is no cure for AIDS and 2.6% said they did not know if there was a cure. 51% of the mothers thought they were personally at risk for HIV/AIDS. When mothers were asked what they can do to protect themselves from getting AIDS, they mentioned the following: 55% - stay with one partner; 23% - don't know what they can do; 21.6% - said there is nothing they can do; 1.5% - abstinence; and 6% - condoms.

Although STDs are common in the project area, syphilis testing (RPR) data can not be provided as the testing supplies are insufficient to routinely collect data and therefore diagnosis for STDs is often made by the syndromic approach. Often when individuals are suffering with a STD, they prefer to go outside of their area for treatment where they do not know the health workers providing the services. Often men being treated for STDs do not bring their partners in for treatment because they do not want them to know. Polygamy is heavily practiced among the Tonga people, and is supported by their belief that the labor force of the household is increased if there are two or more wives who can share the workload. Men are proud of having many children as it is a sign of prestige and the number of wives a man has is a measurement of his strength. Women marry early and a girl is considered to be marriageable once she has her first menstrual cycle. The common understanding is that men can move freely outside the marriage for sexual contacts, but women may not. The local belief in the zone is that the men give their wives a medicine which will cause them to die if they have sexual contact outside the marriage relationship. A woman who cannot bear children will be divorced and it is believed that she is bewitched by her parents or that the sterility resulted from an improperly performed initiation ceremony.

Some of the factors which might facilitate the spread of HIV/AIDS in the area include:

- infidelity of husbands, as it is "acceptable" for men to have additional sexual contacts outside the marriage.
- young girls marrying early, often with older men. Some claim after a few years, these

- women begin to seek sexual contact outside their marriages.
- location of project area along Lake Kariba where many men/visitors come from outside the area to buy fish. Often the women selling or buying fish will use sex to negotiate the price of the product.
- workers from the copper mines in the project area have money to spend, often buying sex.
- truck drivers coming to the area to pick up and transport coal and copper often have sexual contacts among the local population.
- lack of knowledge (and strength to act on the knowledge) among women about how they can protect themselves from HIV infection.
- inacceptability of condom use within marriage.
- lack of dialogue between partners regarding issues related to STDs and HIV/AIDS infection.

4f.2 MOH Policies and Current Activities in Area

The national policies for HIV/AIDS are still under development. The MOH designed a strategic plan for 1994 - 98, which focuses on the establishment of HIV/AIDS/STD policy guidelines (see Annex O) which would address all the various sectors and activities on which AIDS has an impact.

Issues to be addressed within the policy include:

- selected strategies and interventions for the prevention and control of AIDS/STDs
- policies for reducing the impact of AIDS on individuals, families and communities
- review of inheritance laws for surviving family and other legal rights issues related to individuals with AIDS
- strengthening of home care initiatives
- manual for district planning
- reporting system

Currently each district has an AIDS coordinator and these workers are under the supervision of the HIV/TB/Leprosy unit at the provincial health office (which is turn responsible to the national unit). The district AIDS coordinator organizes HIV prevention and control activities in collaboration with NGOs and receives supplies of condoms and pamphlets/education material for training. Although the coordinator has access to transport, his work is limited in that existing funding is split between HIV/AIDS and TB activities. Programs such as workshops and AIDS school clubs, for example, cannot be carried out. The district MOH, Red Cross and WV-Z have sent staff from the project area to receive training in counseling HIV/AIDS/STD patients and families and in provision of home-based care at the well known Chikankata Center, which also trains international participants.

With current practice, results of HIV tests are shared with the patient if the test is voluntary. If the test is done as part of a diagnostic procedure then the results are not shared unless requested. The sero-positivity status of the patients is kept confidential. The MOH allows for non-governmental centers to provide HIV screening as well. Health centers and hospitals must report HIV test results and cases of AIDS-related complex (mandatory reporting). There are national guidelines for the diagnosis and treatment of STDs, and training has been provided to hospital and health center staff in these guidelines. The policy reflects the syndromic approach with the components of confidentiality, counseling, compliance with treatment, contact tracing and condom supply. There

are difficulties with patients not complying with partner notification and contact tracing.

Reproductive health services (ante/post natal care, STD consults, family planning) in Gwembe district are provided from the hospital and 3 rural health centers. In Sinazongwe district, the reproductive health services are provided through 7 rural health centers. Ante/post natal consults and family planning services are available during outreach activities. Contraceptive use in the project area is low, at 9.8%, and family planning services offer a limited selection of available methods. Depoprovera is not widely accepted (due to the ban by the University Teaching Hospital in Lusaka which has since been lifted) leaving mainly oral contraceptives, IUDs and condoms. Condoms are available at the local health centers and with outreach services for both contraception and STD prevention. CHWs also have a condom supply which is distributed free of charge mainly as part of an STD prevention activity. The few local vendors in the area sell condoms at 100 kwacha (about 6 US cents) for a pack of 3 condoms. With the current reporting system, each health center must fill in an STD monthly report which lists several types of STDs and records the number of patients treated that month according to gender and STD. The MOH also has a data collection form (see Annex P) for AIDS community- and home-based care which requests information regarding number of patients visited, number of deaths, number of patients referred, number of AIDS clubs functioning in the catchment area and activities carried out by the clubs. See Annex P for the STD monthly report and AIDS data collection forms.

The current HIV/AIDS prevention/management activities in the project area include the DHMT coordinators' work in providing a condom supply and health education materials (including pamphlets) to the health providers. The coordinator is also working with a limited number of schools in the formation of Anti-AIDS clubs. In Sinazongwe district, the Red Cross has been working among employees of the mining companies distributing condoms, performing some health education activities and training mining staff for peer education regarding HIV/AIDS prevention. The Red Cross (joint exercise with WV-Z) has also trained some of the area's CHWs in HIV/AIDS prevention messages. WV-Z staff have provided health education to church leaders and congregations regarding the transmission and prevention of HIV/AIDS.

4f.3 Approach

The project will work closely with the District AIDS Coordinators in the planning and implementation of the annual HIV/AIDS plan for the district. The project will prioritize its support for the activities which are currently in need of strengthening, including: 1) formation of Anti-AIDS clubs in the schools; 2) workshops to bring together leaders (church, community, district) to dialogue and strategize for the control of the spread of HIV in the project area; and 3) refresher workshops for health workers to design plans and sharpen knowledge/skills for strategically addressing issues of HIV/AIDS/STDs in their catchment areas.

A series of meetings will be conducted with the district AIDS coordinator to review the existing annual plan and make decisions regarding which components would require project support. The project will plan with the coordinator to determine and acquire the resources necessary for the establishment, training, and supervision of AIDS clubs at each of the primary and secondary schools

in the project area. The clubs will be led by trained school teachers and will be supervised on a monthly basis. The purpose of the clubs is to educate children regarding relationships, communication skills, and to address issues of HIV/AIDS (particularly prevention).

The project will also provide technical, logistical and financial support to the coordinator for the implementation of one workshop per year per district for health workers, church leaders, and community leaders to address critical issues related to HIV/AIDS transmission and disease in the project districts. The project will bring in 1) a trainer from another WV-Z project site to provide PLA training, and 2) a WV trainer from the regional office to provide gender and development training for the coordinator and other district and project staff addressing HIV/AIDS issues. These skills will enable the providers to facilitate dialogue with community members to better understand the constraints to behavior change in the prevention of STDs/AIDS, and to increase understanding and communication between partners regarding issues of reproductive health, particularly STDs/HIV/AIDS and child spacing. With the PLA community exercises, current attitudes, beliefs and practices regarding the risk, transmission and prevention of HIV will be explored and applied to better tailor health education messages.

The project will collaborate with the Regional health education unit, Red Cross and other groups working in HIV/AIDS for the review and development of key IEC messages related to HIV/AIDS. Health center and outreach workers, community providers, and community leaders will then be trained in these key messages related to HIV/AIDS prevention and transmission. Health education sessions/ discussions groups will be conducted at health centers, with outreach activities, in churches and at the village level regarding the prevention and transmission of HIV/AIDS. The participatory education sessions which will include presentation of dramas, songs, etc. will focus on facilitating dialogue regarding barriers to risk reduction and behavior change and negotiating skills.

Great emphasis will be placed on targeting men in the communities for health education messages for HIV/AIDS as well as other reproductive health issues, as they are a key link to behavior change and carry the final decision-making authority at the household level. The project training coordinator will meet with the district AIDS Coordinator to strategize and design a plan for the establishment of groups among men regarding HIV/AIDS prevention. Planning and strategizing will also been done with the district AIDS coordinator to decide upon additional appropriate distribution channels for the supply/sale of condoms. The project will contact and collaborate with Population Services International (PSI) and other NGOs/organizations doing similar interventions in other areas of the country to exchange ideas regarding effective avenues for condom supply/sale. The two project staff who have already received training from Chikankata Center will train two leaders (one man and one woman) from each village in the project area in HIV/AIDS counseling.

The district MOH has an STD management component which focuses on the syndromic approach (as mentioned above) and includes training and supervision of health center staff and provision of a drug supply.

D.5 Innovations which may be scaled up

The project will work with the District MOH and UNICEF regarding the establishment of IGA groups for the promotion, manufacture, sale and redipping of impregnated bed nets. If this model is successful, the experience will be shared with the MOH at the Regional level as well as with other WV-Z ADP areas where malaria incidence is high. The project will work with the local health center and neighborhood committees to establish a village based referral/transport system. This system will be used to educate the community about danger signs during pregnancy, labor and delivery which require immediate referral to a health facility, to inform the community about facility services available in the area, and to develop a feasible transport plan. As a major constraint to reducing maternal mortality is establishing timely, dependable transport, this initiative will be closely monitored and if effective, shared with regional MOH office as well as other ADP areas. Gender and development training in relation to issues of child spacing and HIV/AIDS and the formation of men's groups (and CBD initiatives in collaboration with JSI/FSP) will also be monitored and documented to share successes and lessons learned with the Regional MOH office and other CSPs and ADPs operating in the Region.

D.6 SCHEDULE OF PROJECT ACTIVITES

PVO: _____

COUNTRY: _____

	Year 1				Year 2				Year 3				Year 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1. Personnel in Position																
a. Project Manager	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X
b. Technical Coordinator	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X
d. Community/Village Health Workers			X	X	X	X	X	X	X	X	X	X	X	X	X	X
e. Other Support	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X
2. Baseline Survey																
a. Design /Preparation	X	X														
b. Data Collection and Analysis	X	X														
c. Feedback to Community	X	X														
3. Health Information System																
a. Consultants/Contracts to Design HIS			X	X												
b. Develop and Test HIS			X													
c. Implementation			X	X	X	X	X	X	X	X	X	X	X	X	X	X
d. Monthly meetings w/DHMT			X	X	X	X	X	X	X	X	X	X	X	X	X	X
e. Quarterly feedback meetings w/Community				X	X	X	X	X	X	X	X	X	X	X	X	X
4. Service Delivery to be Initiated																
<i>1. Malaria Control -Activities</i>																
Joint planning w/DHMT re: health facility and community prevention, treatment and referral for malaria			X		X				X				X			
Focus groups to determine appropriate careseeking and compliance messages			X													
Review and revise messages w/health education unit			X	X												
Health Education			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Inservice training for CHWs and TBAs in Malaria Control and Management			X	X			X	X			X	X				
Formation and training of IGA Clubs (mosquito net selling)			X	X												
Demonstration and education on mosquito net usage				X					X							
Malaria Week				X					X				X			
Purchasing and distributing of chloroquine to CHWs			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Submit monthly malaria case reports			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Monthly supervision to review malaria activities			X	X	X	X	X	X	X	X	X	X	X	X	X	X
<i>2. CDD-Activities</i>																
Meet w/DHMT to discuss supervision and follow-up on CDD protocol			X		X				X				X			
Focus groups on CDD and home-based care			X													
Review and revision of IEC messages on CDD			X	X												
Meet w/BASICS re: IMCI and CDD training/messages/materials			X													
Health Education			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Refresher course for nurses in diarrhea control and management and family health corner			X				X				X					
Conduct monthly meetings with WASHE	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X
Refresher course for TBAs and CHWs in control and management of diarrheal diseases			X	X			X	X			X	X				
Purchase and distribute ORS sachets to CHWs and TBAs			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Water and Sanitation Week				X					X				X			
Work w/local health centers to strengthen supervision, supply of ORS and reporting			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Purchase and distribute ORT corner kits			X		X		X		X	X			X	X		

D.6 SCHEDULE OF PROJECT ACTIVITIES

Purchase of audio/visual aids for training purchases (e.g., video and monitor, video camera, camera, flip chart board)		X			X													
Purchase of vehicles for outreach activities		X																
PRA Training			X															
Gender meetings			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Develop sustainability plan of action with DHMT and DHMB for outreach				X														
Monthly supervision and inventory of EPI supplies		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
6. Technical Assistance																		
a. Headquarters	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
b. Consultants		X	X		X		X	MT										F
7. Progress Reports																		
a. Annual Reports			X				X				X							X
b. Mid-Term Evaluations							X											
c. Final Evaluation																		X

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Section E. HUMAN RESOURCES

E.1 Organizational Chart

The Organizational Chart for the project is found in Annex Q and Job Descriptions in Annex R. All positions are filled and the project director and HIS coordinator will be MOH staff.

1. Program administrative management will be the responsibility of the project manager with the assistance of the project accountant and secretary.
2. Oversight of technical health activities will be the responsibility of the Project Director and Project Manager with assistance from the Training Coordinator and the WV-Z Director for Technical Services.
3. Monitoring of progress toward objectives will be the responsibility of the Training Coordinator in direct collaboration with the HIS Coordinator under the supervision of the Project Manager.
4. Training of health workers will be the responsibility of the Training Coordinator with the assistance of the team leaders.
5. HIS will be the responsibility of the HIS Coordinator who will receive guidance, assistance and input from the Project Manager and Training Coordinator.

All staff listed on the organizational chart are host country nationals and are full-time employees. The Project Director and HIS Coordinator positions will be filled by the MOH or DHMT for Gwembe Valley. The CHWs, TBAs and neighborhood committees are volunteers and will respond to and receive guidance from the family health nurses as well as from the health staff at the health centers and those serving on the outreach teams.

E.2 Health workers

District MOH staff working in the two districts of Gwembe and Sinazongwe who are involved in the provision of primary health care/child survival interventions are listed in the chart in Annex B. Two of the project nurses were already working with WV-Z in a primary health care project supported through the Canadian Public Health Association. The additional three nurses and Training Coordinator recruited in the month of January are family health nurses who are newly retired from the MOH and the Training Coordinator just retired from the MOH southern Province Regional Office. All have been involved in the provision of primary health care services in the Region with the majority having more than 20 years of experience in the delivery of rural health services. The Project Manager is a nurse who has been working with WV-Z for a number of years implementing primary health care programs and most recently responsible for the implementation of a child survival program funded by the Australian government in another area of the country. The above mentioned workers are all full-time staff and will be working over 40 hours per week in the mobilization, training in and delivery of child survival interventions including malaria control, diarrhea prevention and control, maternal care, child spacing, universal child immunization and prevention of HIV/AIDS. Collaboration will take place with Red Cross workers, Gwembe Catholic sisters and with Momba Mining Company nurses providing services in the districts.

In comparing the staffing pattern for the child survival program with that of other similar non-

program areas, the difference is that the additional 2 nurses per district will enable the district MOH to complete and cover half of their outreach services for those communities with the lowest access to care. The presence of a Training Coordinator will provide an opportunity to strengthen the quality of care health workers provide, mobilize community-based initiatives and provide training and materials for health education to be delivered in an effective fashion. The project has selected the staff in order to provide an opportunity for communities to learn more about the prevention and home management of frequent illnesses contributing to the high infant and child mortality rates in the Valley and in order to create stronger linkages between the community and the health system so that the services are used in the most appropriate and cost effective fashion.

There are currently 105 CHWs serving in Sinazongwe and 85 CHWs in Gwembe. These volunteers have the role in their communities of providing treatment for minor ailments (can also provide malaria treatment and ORS packets for diarrhea episodes), mobilization for outreach activities/services, health education activities/promotion of key preventative and home management messages. These volunteers work 20-30 hours per week in their villages and are provided with a bicycle and simple materials which enable them to perform their work duties (backpack, notebook, pen, pencil, etc.). There are 56 TBAs serving in Sinazongwe and 52 TBAs serving in Gwembe district. The project will assist the DHMT in supervising half of these existing TBAs. The TBAs perform an average of eight deliveries per year, but also work up to 30 hours a week assisting with the mobilization of communities for outreach services and participation in antenatal care. They also dedicate time to providing health education to the villages in which they serve. Although the policy stipulates that each volunteer CHW provide coverage for a population of 500, the reality is one CHW to 1,000 homesteads. Since 1991, where support has been provided for monthly supervision and the purchase and supply of bicycles, lamps and delivery kits as incentives, the dropout rate among volunteer CHWs and TBAs has been very low. There have also been competitions based on data collection and use of information conducted which were very successful in motivating workers with prizes of t-shirts and blankets offered. Since 1991, only 3 CHWs have been replaced: one worker was appointed village chief and could not continue with both responsibilities, one got married, and the other relocated. Two TBAs were also lost due to death due to illness.

The replacement of workers/project staff is expected to be about one per year, most likely due to illness including AIDS, which has become more and more a reality in Zambia. The replacement of volunteers is expected to be one every 1-2 years due to illness, transfer or additional duties. To minimize replacement, the project will aim to select individuals who appear most likely to remain in their positions, to provide consistent support to the project team and volunteer workers (staff development/in-service training, adequate salaries, participation in decision-making, supervision etc.) to maintain morale and quality.

E.3 Supervision Plans

The Project Manager, Training Coordinator and two team leaders will be responsible for ongoing training, observations and review of progress, knowledge and competency, as well as bi-annual or annual performance reviews. Supervisory and quality assurance checklists will be created or adapted with assistance from BASICS. Exit interviews and pre- and post-training tests will also be used to

monitor competency. The Project Director and Manager will have overall supervisory responsibilities. The following table outlines the supervision that will be provided to each cadre of health worker and how often supervision will occur.

Cadre of Worker	Supervisor	Activity	Frequency of Visits
190 CHWs existing 95 targeted (40 new) by end of project	4 Outreach Team members per district (2 to 3 project staff, 2 MOH staff)	Discuss problems, check, sign and analyze registers, resupply kits, talk to mothers to check quality of services	once every 28 days
108 TBAs existing 54 targeted	4 Outreach Team members per district (2 to 3 project staff, 2 MOH staff)	Discuss problems, check, sign and analyze registers, resupply kits, talk to mothers to check quality of services	once every 28 days
CHWs/TBAs	Rural Health Center	Collect registers and develop summary report to be submitted with health center monthly report. Use as a basis for restocking/reordering supplies	Once a month (data report submitted to regional office)
3 Family health nurses	2 Team Leaders (senior nurses)	Work together on a daily/weekly basis with FH nurses providing on-site supervision throughout the month as well as annual performance evaluations	Daily/routine visits, yearly performance appraisals, monthly team meetings
2 Team Leaders (senior nurses)	1 Project Manager	Visits team leaders on site, discusses problems, reviews reports, performance appraisals	Monthly on-site supervision, review of reports, monthly management meetings, annual performance appraisal
1 Training Coordinator	1 Project Manager	Monthly on-site visits to discuss quality of work and constraints, monthly management meeting for review of needs/successes etc., monthly review of reports, annual performance apPLAisals	Monthly Annually
1 Project Manager	1 Project Director	Weekly meetings with Project Manager, review of monthly project reports, annual performance apPLAisals for Project Manager, approval on all other project staff performance apPLAisals	Weekly meetings, monthly project management meeting, annual apPLAisals, review of quarterly reports

1 Project Director	WV Director for Technical Services	Reviews monthly and quarterly reports, visits project every quarter to discuss problems/progress, completes annual apPLAaisal with operations director for Southern Region	Monthly, annually, quarterly
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E.4 Community Committees and Groups

The neighborhood committees will consist of 10 members, consisting of 6 women, 4 men and a chairman. For every delivery point, there will be a neighborhood committee formed (there are 16 in Gwembe and 18 in Sinazongwe served by the project). The committees will meet monthly and receive a visit from the outreach team supervisor every month. Their responsibilities will include identifying their own health problems, prioritizing problems and planning activities for resolution of problems in collaboration with MOH outreach team and CHWs serving in area.

In coordination with the district AIDS Coordinator, an AntiAIDS club will be formed at each primary school in the area. The clubs will receive on-site guidance from the teachers trained and will receive a visit from the Training Coordinator/outreach team leaders each month. The men’s clubs to be established for dialogue regarding HIV/AIDS and child spacing will be subgroups of the neighborhood committees and will meet on a quarterly basis. Other groups which will be collaborating with the project on child survival initiatives include the WASHE committees whose responsibilities will include health education/diarrhea prevention, maintenance of water pumps, and mobilization for latrine construction, and the women’s “backyard garden” clubs (who also work with small livestock) formed in collaboration with WV Development Assistance Centers. There are 17 of these women’s groups in Gwembe and 20 in Sinazongwe. These groups focus on agriculture and nutrition activities and are trained in small business principles. Most of the groups have received loans and established bank accounts. An additional 6 - 8 IGA groups will be established for the marketing and selling of impregnated mosquito nets.

E.5 Role of Country Nationals

Country nationals are responsible for the management of the project with support and guidance from WVRD regional and headquarters staff. All project positions are filled by Zambian nationals. Plans for enhancing project’s staff skills include a 2 - 3 week management course in Lusaka for the Project Manager and Training Coordinator. Training in SunSystems and grant management for the Project Accountant will be provided by WVRD headquarters staff with cross- program visits with WV Zimbabwe. Training for the Project Manager, Training Coordinator and family health nurses in project design, planning, monitoring and evaluation by WVRD regional and headquarters staff will take place twice a year. Initial training took place with KPC survey and DIP preparation, and annual reports will be used to analyze lessons learned, successes achieved, constraints being encountered and realistic solutions, progress towards objectives, effectiveness of strategy and steps towards enhancing sustainability. As resources permit, opportunities will be taken to participate in regional child survival workshops and cross-country visits with WV CSPs in Malawi, South Africa and

Mozambique.

E.6 Role of Headquarters Staff

PVO headquarters technical and managerial support will be provided by Ms. Martha Holley Newsome, WVRD Child Survival/Primary Health Care Manager. Regional support will be provided by Ms. Anne Henderson, WVRD Regional Health Advisor. Dr. Kwasi Nimo, Regional Health Co-ordinator for Africa and Health Advisor for Zambia will also provide technical support from Zambia. Headquarters or regional support will be provided for: 1) KPC survey training, implementation and analysis at baseline; 2) preparing the detailed implementation plan (DIP); 3) carrying out Mid-term and Final Evaluations; 4) providing technical literature, training materials and training on an as needed basis; 5) providing general guidance regarding technical and management issues; 6) establishing key linkages with other USAID (as well as other donor) supported initiatives at work in Zambia and in the Region; and 7) sharing of lessons learned and creative initiatives of WV CSPs on the African continent. Additional financial assistance and training will be provided by Mr. Chris Hogue, WVRD Finance Officer. Issues and training regarding our cooperative agreement will be supported by Ms. Grace Buck, WVRD Contracts Officer.

The Regional Health Advisor will make consultancy visits (each lasting 10 days) twice each year to provide training and technical assistance. Dr. Nimo, the Technical Services Advisor/Africa Health Coordinator based in Lusaka, will visit the project on a quarterly basis. Mr. Hogue will visit the project twice to provide support to the project financial management staff. The headquarters personnel will also participate in the Mid-term (FY'98) and Final Evaluations (FY'20) and will spend two weeks in the field with each exercise working with project staff.

Section F. PROGRAM MONITORING HEALTH INFORMATION SYSTEM

F.1 HIS Plan

The progress of the project will be monitored using the current data collection system of the district MOH along with a community based register system which is kept by the CHWs and TBAs working at the village level (see Annex I for CHW forms.) Information will be submitted in the form of monthly, quarterly, and annual reports. Special reviews of the project led by external consultants will be done at midterm and end of the project period. The project will monitor program activities and services provided to project participants in addition to a census based tracking for WCBAs and children under five in villages where CHWs are serving. The MOH data collection system has a strong base in relation to the types of data being collected, but the weakness rests in the analysis and use of the information being gathered. The project through the leadership of the HIS coordinator who will establish linkages with the Southern Region HIS officer, District MOH HIS officer, and health center supervisors for training, analysis and planning exercises based on data being collected. The project will also work through the local outreach teams, CHWs and neighborhood committees to promote and explore community feedback mechanisms for the health information being collected. The BASICS project will be consulted regarding their recent developments for CHW data collection base and survey/checklist tools to assist supervisors in monitoring the quality of services being delivered.

F.2 Data Variables

The HIS collection system principles are:

- The information being collected should support decision making.
- Information collected should identify and monitor the health needs of the population.
- Feedback regarding the quality of care should be elicited and collected from both patients and staff.
- Information collected should monitor the progress towards achieving project objectives.
- Information must be freely available to all within the system, but confidentiality must be maintained.
- Information should be easily transferrable from one system to another.
- Information must be submitted and used in a timely fashion.
- The system should integrate the private sector (including traditional healers, etc.)
- Staff at all levels should be involved in the use of the information system as a basis for decision making and service monitoring and data should always be analyzed and used at the level at which it is collected before it is passed up the system.

Data variables which will be collected under the supervision of the HIS coordinator and submitted through the format of monthly, quarterly and annual reports include:

INDICATOR	TOOL	FREQUENCY	COLLECTOR
Malaria			
Number of malaria cases treated at health center, through outreach team services and at village level through CHWs.	Clinical records	Monthly	Health center staff*, outreach nurses, CHWs
Number of health education sessions delivered regarding prompt careseeking practices for acute malaria episodes and services available.	Activity reports	Monthly	Health center and outreach nurses and CHWs
Number of villagers purchasing impregnated nets through established IGAs	IGA Sales records	Quarterly	IGA groups
CDD			
Number of diarrhea cases treated at health center, during outreach activities and at village level through CHWs with ORT	Clinical records	Monthly	Health center and outreach nurses, CHWs
Number of health education sessions delivered regarding key diarrhea management and preventions messages	Activity reports	Monthly	Health center and outreach nurses, CHWs
HIV/AIDS			

Number of Anti-AIDS clubs established in local primary and secondary schools.	Activity reports	Quarterly reports	Training Coordinator
Number of men's groups established for dialogue and education regarding reproductive health issues including HIV/AIDS/STDs and family planning.	Activity reports	Quarterly reports	Training Coordinator
Maternal Care			
Number of women making first time prenatal consults.	Patient records	Monthly	Health center and outreach nurses
Number of women making followup prenatal consults	Patient records	Monthly	Health center and outreach nurses
Number of pregnant women receiving malaria treatment or iron supplementation	Patient records	Monthly	Health center and outreach nurses
Number of pregnant women delivering at health center.	Clinic records	Monthly	Health center staff
Number of women making post partum consults	Clinic records	Monthly	Health center and outreach nurses
Number of health education sessions conducted at village level regarding dangers signs requiring immediate referral to health facility	Activity reports	Monthly	Health center and outreach nurses, CHWs.
Number of communities where neighborhood committee is supporting a village referral transport system	Annual count	Annually	HIS Coordinator
Family Planning			
Number of CBD agents trained and providing education and services at the village level	Activity reports	Annually	Training Coordinator
Number of new acceptors to family planning according to method chosen	Clinic records	Monthly	Health center and outreach nurses, CBD agents
Number of continued users of family planning according to method chosen	Clinic records	Monthly	Health center and outreach nurses, CBD agents
Number of health education sessions regarding benefits of child spacing and services available delivered to WCBA and their partners and communities	Activity reports	Monthly	Health center and outreach nurses, CHWS
Immunization			

Number of children completely immunized according to age group (less than 1 year, or > 1 year)	EPI forms	Monthly	Health center and outreach nurses
Number of pregnant women receiving TT2.	EPI forms	Monthly	Health center and outreach nurses
Number of WCBA s receiving TT5	EPI forms	Monthly	Health center and outreach nurses
Number of cases of measles, polio and tetanus according to age group and vaccination status.	Clinic records	Health center and outreach staff	Health center and outreach nurses, CHWs

*Clinical officers, nurse/midwives and nurses.

In addition to the above mentioned variables, baseline data variables regarding key child survival indicators were measured in February 1997 and the survey will be repeated at the end of the project. The specific indicators targeted for project input can be observed in Table B, Section B. The Mid-term and Final Evaluations will provide a format for measuring progress towards project objectives and indicators as well as an analysis of the effectiveness of the strategy/process being used to achieve these results.

For qualitative data, communities will be mobilized through PLA sessions to explore current beliefs and PRACTICES regarding the cause, prevention and treatment of common illnesses as well as care seeking PRACTICES. These group sessions will be conducted on a yearly basis and will help provide data to the team regarding perceptions and possibly preferences toward available services. Focus groups will be used to revise and refine project messages for each of the interventions targeted. A more detailed qualitative assessment study will be designed and conducted at the Midterm Evaluation to assess project performance and quality of health facility and community services. Observations of health center and outreach supervision visits as well as the neighborhood committee meetings will also provide qualitative input into the project data base and will be reported through quarterly and annual reports.

F.3 Data Analysis and Use

The HIS Coordinator will have the primary responsibility for ensuring that data is analyzed and presented according to district policies and format as well as donor requirements. (See Monthly Return for Health Centers and Sub-centers in Annex S.) The coordinator will take the role of mobilizing and training staff who collect data at all levels in issues of accuracy, confidentiality and analysis and use of the data in targeting and evaluation of services and addressing the health needs of the population. The HIS Coordinator will have the responsibility of working with the district teams to keep relevant information visible, current and in a format that can be easily understood by the various users, whether it be the MOH, project staff, community providers or the community itself. Community feedback will be provided in collaboration with the outreach team, CHWs and neighborhood committees on a quarterly basis.

Monthly reports will be compiled by the Project Manager and HIS Coordinator and will be submitted to the WV-Z head office, district and regional MOH offices and to collaborating agencies. Summary quarterly reports will be submitted to the WV-Z and regional and headquarters offices. The reports will include a narrative section containing significant achievements based on the proposed plan of action, constraints encountered and resolutions made/proposed, and plans for the upcoming period. A data section including numbers/percentages reached according to the above proposed data variables according to intervention will also be included. The Project Accountant in coordination with the Project Manager will be responsible for the financial section, relating project expenses to planned expenditures and planning for the upcoming period.

Monthly meetings will be conducted between project management and the DHMT to review the monthly reports and significance of data collected for the targeting of services. Monthly meetings will also be held with project and district health center and outreach staff where the HIS coordinator will highlight significant data findings and trends. In this context discussion regarding the practical application of the data will occur. During quarterly community feedback sessions, time will be given for the community to express their perceptions, satisfaction or disappointment with the delivery of health services, as well as explore their role in improving the health status of their own populations.

Data collected on specific variables will be used to improve the coverage/quality of intervention activities as follows⁶:

- **Malaria:** Number of bednets being purchased will assist to evaluate acceptability and affordability of the nets and effectiveness of the promotion campaign;
- **Diarrhea Control:** Number of diarrhea cases being treated with ORT will assist to evaluate the incidence of diarrhea in the project area as well as seasonality influence to best target timing of prevention initiatives;
- **HIV/AIDS:** Number of mens' groups established for the dialogue and instruction regarding HIV/AIDS prevention will assist in the evaluation of efforts to involve men in dealing with these critical issues at the household level;
- **Maternal Care:** Number of pregnant mothers delivering at the health center will assist with the evaluation of access to and acceptability of existing labor and delivery services;
- **Family planning:** 1) Number of new acceptors will assist to evaluate the impact of health messages being promoted regarding child spacing as well as acceptability of family planning as access is increased through the efforts of CBD agents; 2) number of continued users will assist with the evaluation of the quality of services in terms of good counseling and follow-up provided with consults;
- **UCI/EPI:** 1) Number of WCBAs receiving TT5 will assist in evaluating the effectiveness of health education regarding vaccine purpose and doses required for full protection; 2) number of children immunized before age one will assist to evaluate access to and

⁶The Midterm qualitative assessment will include client interviews to determine perceived quality of services provided.

knowledge/acceptance regarding immunization calendar.

F.4 Other HIS Issues

As part of the HIS training initiatives, health center and outreach staff and community providers will be instructed regarding the importance of data confidentiality. MOH guidelines for data use and its protection will be reviewed with health staff working in the district.

Technical assistance has already been provided by the WVRD regional health support person for the training and implementation of the baseline KPC survey. Technical assistance will also be required from the regional and headquarters office for compiling of project and financial reports, and effective use of data for decision making. Technical assistance from within WV-Z will be called upon for effective implementation and use of data obtained from PLA exercises. Technical assistance from the BASICS project in relation to CHW data collection and information collected with supervisory visits will also be sought out. The HIS is expected to be operational by year 2 of the project implementation.

Materials and equipment which are needed for the HIS include:

- Antenatal/postpartum cards
- TT cards
- Growth monitoring cards
- Forms for tallying information during curative consults, EPI activities, GM activities, etc. (all to be provided by the MOH)
- Calculators will be purchased for health center, outreach and CHW workers, project accountant and HIS coordinator
- One computer and printer will be purchased for use by project management and HIS coordinator
- Charts and markers will be purchased to facilitate making the data visible to both health workers and for community feedback presentations
- Folders and filing cabinet will be purchased in order to store project information in an orderly fashion.

G. SUSTAINABILITY

G.1 Sustainability Goals, Objectives, and Activities

The two major sustainability goals are: 1) Communities will be able to advocate for their basic preventative and curative health needs and will adopt preventative and home management messages; and 2) DHMTs will deliver quality primary health care services in collaboration with community providers as close to the household level as possible. To sustain project activities the DHMTs will have to assume the costs associated with the outreach activities, including: staff, vehicles, and fuel. Communities will have to assume the costs of supporting the CHWs and TBAs. Health messages which are understood, accepted and can be incorporated at the household level will need to be delivered in an effective manner to the targeted groups. To achieve this, the MOH has been involved in planning during the project proposal stage, KPC, and the DIP design. Monthly planning meetings

will be conducted with the DHMTs and quarterly planning/monitoring meetings with the Provincial MOH team. Each district will budget for their own activities and the project accountants will provide support. The district staff, together with project staff, will be carrying out the training and supervision of community staff as well as evaluation and focus group activities to develop messages and materials. The project will use the MOH HIS system and HIS Coordinator office and will provide training in using data for decision making based on monthly, quarterly, and annual reports. In preparation for the Midterm Evaluation, the regional support person, will work with the project management in collaboration with representatives from the MOH and communities to apply the "Sustainability Readiness Index" tool in order to clearly highlight the key steps and plan of action required to move services and practices into the long term plan for the area. (See Annex T for the Sustainability Readiness Index.)

To address these goals, the project will link the DHMTs and the community beneficiaries through neighborhood health committees, CHWs, TBAs, and CBDs for the continued promotion of child survival messages and mobilization of primary health services. Updated training materials, references and resources for child survival interventions for DHMTs and community providers will be available at the health centers, outreach delivery points as well as at the village CHW post. Resources will include materials focusing on effective communication skills and health education delivery methods. The project HIS will be fully integrated with the MOH HIS and will provide the data that the communities and the DHMT need to aid decision making and problem solving. District funds are already allocated towards supplying necessary drugs (including contraceptives, ORS packets, malaria treatment and basic antibiotics), cold chain equipment, EPI vaccines, growth cards and the project will focus on improved planning and management.

G.2 Community Involvement

The communities priorities include water, particularly during drought, basic health services, and food security. The former Canadian Public Health project enabled staff to dialogue with target communities regarding their priorities and felt needs. As a result, WV-Z mobilized funds and worked with community water committees to establish over 30 protected water sources. The water committees take responsibility for maintaining the water source, organizing the community to purchase spare parts, and mobilizing education regarding water use and storage and necessary sanitation measures. The water and sanitation team received another grant and is continuing its collaboration with village members to establish more protected water sources. In addition to water, the communities greatly value access to vaccinations and basic health services for the treatment of acute illnesses as evidenced by the high participation in outreach activities. In response to community request and DHMT planning, WV-Z provided materials and the communities provided the labor to construct two additional clinics for areas that were previously located 50km from the nearest health center.

Communities members have been involved in planning for the project by reviewing the KPC data and developing follow up plans. The area Chief and Councilmen participated in the survey results debriefing and analysis. The community will also be involved in conducting focus groups to explore their current beliefs and practices and in conducting PLA and gender exercises, providing

a chance to dialogue about how to cope with critical issues such as HIV/AIDS, family planning, obstetric emergencies, etc. Informal and formal community leaders will be involved in project planning meetings. Training and follow-up for neighborhood health committees regarding problem solving and analysis will also be carried out. Community volunteers were significantly involved in the National Immunization Days for the Eradication of Polio, and the project will build on these experiences for other PHC interventions. The project will continue to encourage public involvement in program activities through mobilizing women's groups, men's groups, neighborhood committees and community providers to participate in the planning, promotion and delivery of health education messages and primary health services. These communities have already been directly involved in selecting and supporting their CHWs and TBAs with gifts in kind. Initiatives for cost recovery of selected services will be explored (see Section G.4, Cost-recovery, below). The Sustainability table at the end of Section G includes more information about objectives and activities planned to ensure that communities can advocate for their health needs as well as adopt basic preventative and home management messages. Quarterly community feedback sessions facilitated by the CHWs and neighborhood committees will take place, during which time key data results (diarrhea / malaria incidence, number children under one completely immunized, number low birth weight infants, antenatal care attendance, child spacing users) from that quarter will be shared with village members. These feedback sessions will enable the community to discuss causative factors and to formulate feasible solutions.

G.3 Phase-over Plan

All child survival interventions will be fully integrated into the District health delivery system and collaborating communities. Each year the project will establish a written agreement with the DHMTs regarding roles and responsibilities for the delivery of outreach services, providing an opportunity for the DHMTs to gradually assume greater responsibility for all service delivery. The project and district accountants will be included in these exercises so that the budget will be able to support the decisions and agreements made. A phase out plan will be developed with the DHMTs that includes the transfer of some outreach staff members, transport, and community level supervision responsibility by year three of the project. The process of decentralization provides an opportunity for the DHMT to sustain project activities by moving the management of health funds to the district level. The Zambia health reform has renewed local commitment to the delivery of primary health care services with the involvement of the community as close to the household as possible. The district health services and project training being conducted to achieve this reform is strengthening the capacity of the district system and health care workers to carry out this mandate. Evidence which shows that communities can sustain activities is: 1) low volunteer drop out rates despite limited incentives; 2) high vaccination coverage and low drop out rates; and 3) reasonably high ORT usage rate. The KPC data showed that villages were adopting some of the health messages being promoted, suggesting that increased promotion would result in greater knowledge and adoption rates. The plan for strengthening the management skills of the DHMTs so that they can better sustain activities will mainly consist of "on the job" transferring of skills for:

- service planning
- data use for decisions
- valuing and commitment to supervision

- community mobilization skills
- health education methodologies and key messages
- and tools which can help monitor the quality of services being provided.

These skills will also be strengthened through yearly workshops and collaboration/interfacing with support projects operating in Zambia (BASICS, Family Services Project).

The CSP is being integrated into a 10-15 year WV-Z area development program (ADP) which addresses simultaneously a variety of development needs in a defined region. Thus WV-Z will also be addressing needs for project planning, IGAs, community gardens, food security, community planning and development, and water and sanitation needs all of which act in a complementary fashion to enhance overall community health.

Cost effectiveness will be maximized. Where opportunities exist, DHMT and project staff will be trained by other organizations offering such training (i.e. JSI CBD training, IMCI training, etc.) When possible, incountry or regional trainers will be used for ongoing CS training, monitoring, and evaluation. Further assistance will be sought locally and abroad to cover the cost of project supplies and training materials. This may even take the form of goods-in-kind.

G.4 Cost Recovery

The project will work with the DHMTs and communities to explore the feasibility of establishing some cost recovery systems. The PLA exercises, focus groups and “Sustainability Readiness Index” will provide an opportunity to explore the communities willingness and ability to pay for services and incentives for community workers. Cost-recovery will be used to make, sell, repair and re-dip impregnated bed nets. The project will dialogue with UNICEF and the DHMTs regarding this proposed cost-recovery activity for which the training coordinator will be responsible. The JSI Family Services Project is exploring cost-recovery initiatives as part of the CBD and the project will maintain a dialogue with them to learn and apply their models and lessons learned. WV-Z, through other development initiatives in the area continues to establish income generating activities and has had success in applying small business principles, paying back loans as well as opening back accounts.

GWEMBE VALLEY CSP SUSTAINABILITY GOALS, OBJECTIVES AND ACTIVITIES

Sustainability Goals	Objectives	Activities Required
<p>1. Communities will be able to advocate for their basic preventative and curative health needs and will adopt basic preventative and home management messages (specifically re: to diarrhea, and other water related diseases)</p>	<p>a. Effective health education messages which are acceptable to the community delivered at health facility, through outreach activities and at the village household level. Involvement of community in the development of IEC messages through focus groups.</p>	<p>a. Community members participate in focus groups to explore their current understanding and beliefs regarding the targeted project interventions (ex. Diarrhea, malaria, HIV/AIDS).</p>
	<p>b. Involvement of key opinion leaders and planners from WV/MOH/Community in evaluation activities and key planning and project management meetings.</p>	<p>b. Invite formal and informal community and government leaders to project planning and management meetings. Provide regular data feedback to these groups.</p>
	<p>c. Training and supervision of community providers for the provision of health education and basic services, which are close to the people, adapt the message to the culture, and are chosen/selected by the community to ensure acceptability and support.</p>	<p>c. Joint planning with District MOH team regarding numbers and schedule and supervision for training of community based providers.</p>
	<p>d. Neighborhood committees skillfully trained to prioritize and problem solve health issues and concerns within their communities.</p>	<p>d. Provide training and followup for neighborhood committees regarding problem analysis and solving skills. Conduct PLA and gender exercises at the community level.</p>
	<p>e. Involvement of men in health education and interventions especially those related to child spacing and HIV/AIDS issues.</p>	<p>e. Joint coordination and planning with District MOH team and Village leaders for the key involvement of men for messages and services related to child spacing and HIV/AIDS prevention.</p>
	<p>f. Development and implementation of supervisory and support linkages between health facility and community providers (CHWs, TBAs, Traditional Healers, Neighborhood committees)</p>	<p>f. Joint planning and support with MOH team for the supervision of community based providers. Provision of incentives for CHW.</p>

<p>2. Project District MOH teams will deliver quality primary health care services in collaboration with community providers and as close to the household level as possible.</p>	<p>a. Involvement of District MOH staff in KPC baseline and end of project surveys and evaluation exercises for targeted planning of primary health care activities and key health messages.</p>	<p>a. Collaborate with Provincial and District health directors to form survey and evaluation teams with key health staff participating including those involved in program decision making.</p>
	<p>b. MOH district health center and outreach staff to be involved in the training and supervision of community based providers.</p>	<p>b. Health facility staff to be involved in the planning, training, and supervision of CHWs, TBAs, and neighborhood committees.</p>
	<p>c. Monthly planning meeting with analysis of district health statistics with District MOH team and quarterly planning/monitoring meetings with Provincial MOH team.</p>	<p>c. Project management to arrange for monthly meetings with District MOH management team and quarterly meetings with Provincial MOH team.</p>
	<p>d. Training, supervision and followup of District MOH staff in delivery of quality PHC services and key educational messages and methodologies.</p>	<p>d. Training of -- health workers in planning, management, supervision, HIS use, EPI, CDD, mgm of malaria, maternal care, child spacing and HIV/STD prevention and management.</p>
	<p>e. Project to use existing HIS MOH system for reporting purposes and data collection and provide training and routine example on use of data for planning and management purposes.</p>	<p>e. Strategically use existing MOH forms focusing on the analysis and application of statistics being collected.</p>
	<p>f. Project finance staff to provide monthly training to District health management team staff regarding principles of managing a budget as well as concrete plan for gradual assuming of responsibility of activities and recurrent costs. No agreement has been drafted or signed.</p>	<p>f. Monthly training sessions for MOH district health team regarding principles of managing a budget and planning for recurrent operation costs.</p>

SECTION H

ZAMBIA CSP FIELD BUDGET
 Period: Sept. 1, 1997 to Sept. 30, 2000

	Year 1		Year 2		Year 3		Year 4		TOTAL		TOTAL
	USAID	WV	USAID	WV	USAID	WV	USAID	WV	USAID	WV	
DIRECT COSTS											
A. PERSONNEL											
1. Technical											
a. Health Coord.	10,419			11,461		12,607		13,868	10,419	37,936	48,355
b. Training. Coord	9,803		10,783			11,862		13,048	20,586	24,910	45,496
c. Regist. Nurses/Midwives (2)	26,357		19,329		17,673	3,588		23,389	63,359	26,977	90,336
d. Family Health Nurses (3)	37,955		25,051		27,556		30,311		120,872	0	120,872
Sub-total	84,534	0	55,162	11,461	45,229	28,057	30,311	50,305	215,236	89,823	305,059
2. Other Personnel											
a. Finance Admin.	9,523		10,475		11,523		12,675		44,196	0	44,196
b. Sec	5,937		6,531		7,184		7,902		27,554	0	27,554
c. Drivers (3)	14,931		16,424		18,067		19,873		69,295	0	69,295
d. Guards (2)	10,991		8,060		8,866		9,753		37,670	0	37,670
Sub-total	41,382	0	41,490	0	45,640	0	50,203	0	178,715	0	178,715
SUB-TOTAL - PERSONNEL	125,916	0	96,652	11,461	90,869	28,057	80,513	50,305	393,951	89,823	483,774
B. TRAVEL/TRAINING											
1. In-country											
a. Vehicle Fuel/Main/Rep	10,800		11,500		15,000		10,000		47,300	0	47,300
Sub-total	10,800	0	11,500	0	15,000	0	10,000	0	47,300	0	47,300
2. International											
a. Workshops/Conferences				5,000					0	5,000	5,000
Sub-total	0	0	0	5,000	0	0	0	0	0	5,000	5,000
SUBTOTAL - TRAVEL	10,800	0	11,500	5,000	15,000	0	10,000	0	47,300	5,000	52,300
C. CONSULTANCIES/EVALUATION											
1. Evaluation/Consultants fees											
a. Baseline Survey	4,000								4,000	0	4,000
b. DIP	1,500								1,500	0	1,500
c. Mid-term Evaluation				5,000					0	5,000	5,000
d. Final Survey								4,600	0	4,600	4,600
e. Final Evaluation								6,000	0	6,000	6,000
SUBTOTAL CONSULT./EVAL.	5,500	0	0	5,000	0	0	0	10,600	5,500	15,600	21,100

SECTION H

ZAMBIA CSP FIELD BUDGET

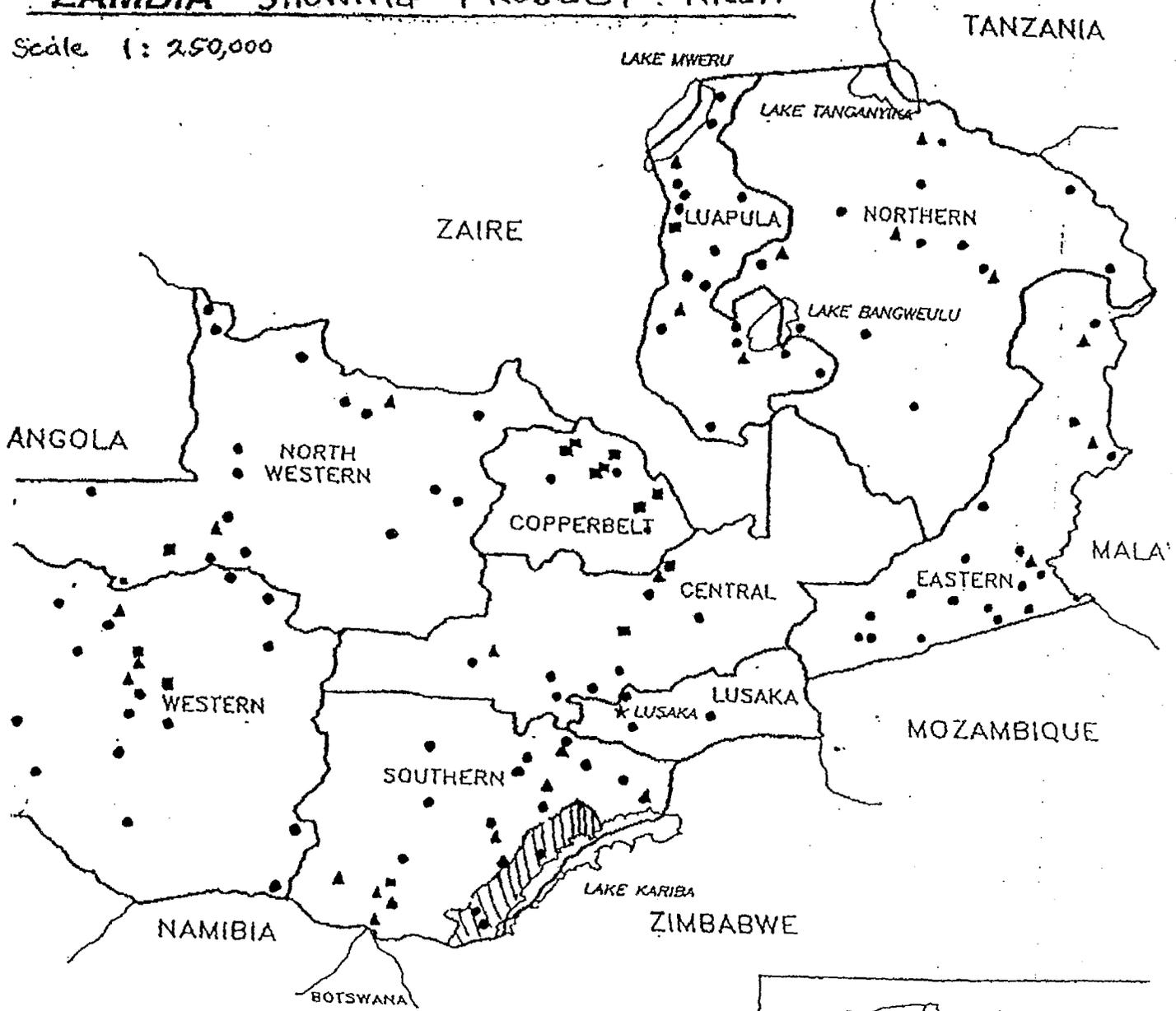
Period: Sept. 1, 1997 to Sept. 30, 2000

	Year 1		Year 2		Year 3		Year 4		TOTAL		TOTAL
	USAID	WV	USAID	WV	USAID	WV	USAID	WV	USAID	WV	
D. SUPPLIES & EQUIPMENT											
1. Supplies											
a. Office	2,000		2,200		2,420		2,662		9,282	0	9,282
b. Technical	2,000		3,000		1,000		500		6,500	0	6,500
c. Medicines		2,000		2,000		2,000		2,000	0	8,000	8,000
d. Training	1,000		2,500		1,000		500		5,000	0	5,000
Sub-total	5,000	2,000	7,700	2,000	4,420	2,000	3,662	2,000	20,782	8,000	28,782
2. Equipment											
a. Office	2,000		1,500		600		600		4,700	0	4,700
Subtotal	2,000	0	1,500	0	600	0	600	0	4,700	0	4,700
3. Capital Equipment											
a. Computers/Printers	3,000								3,000	0	3,000
b. Vehicles (3)		90,000							0	90,000	90,000
c. Cold Chain	1,000		3,000		1,000				5,000	0	5,000
Subtotal	4,000	90,000	3,000	0	1,000	0	0	0	8,000	90,000	98,000
SUBTOTAL - SUPPLIES/EQUIPMEN	11,000	92,000	12,200	2,000	6,020	2,000	4,262	2,000	33,482	98,000	131,482
E. OTHER DIRECT COSTS											
1. Communications											
a. Telephone/Fax/DHL/E-mail	2,000		2,200		2,420		2,662		9,282	0	9,282
2. Facilities											
a. Office Rent	3,200		3,520		4,280		4,500		15,500	0	15,500
b. Utilities	500		550		650		797		2,497	0	2,497
Subtotal	3,700	0	4,070	0	4,930	0	5,297	0	17,997	0	17,997
3. Training											
a. Field Training Workshops	3,500		4,000		4,000		3,000		14,500	0	14,500
4. Field Admin. & Support Costs		33,299		15,285		15,563		16,572	0	80,719	80,719
SUBTOTAL - OTHER DIRECT COST	9,200	33,299	10,270	15,285	11,350	15,563	10,959	16,572	41,779	80,719	122,498
TOTAL DIRECT COSTS	162,416	125,299	130,622	38,746	123,239	45,620	105,734	79,477	522,012	289,142	811,154
INDIRECT COSTS (20.5%)	32,475	7,236	26,163	7,943	25,059	9,352	21,676	16,293	105,372	40,824	146,197
TOTAL COSTS	194,891	132,535	156,785	46,689	148,298	54,972	127,410	95,770	627,384	329,966	957,350

ANNEXES

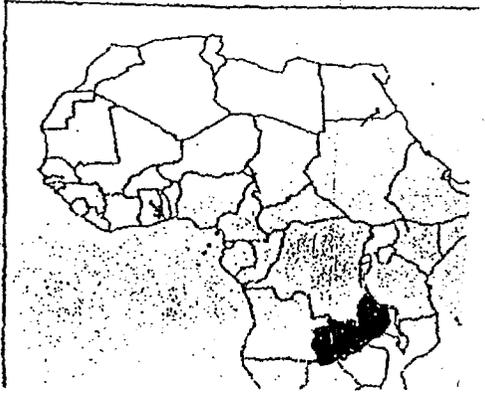
MAP OF ZAMBIA SHOWING PROJECT AREA

Scale 1: 250,000

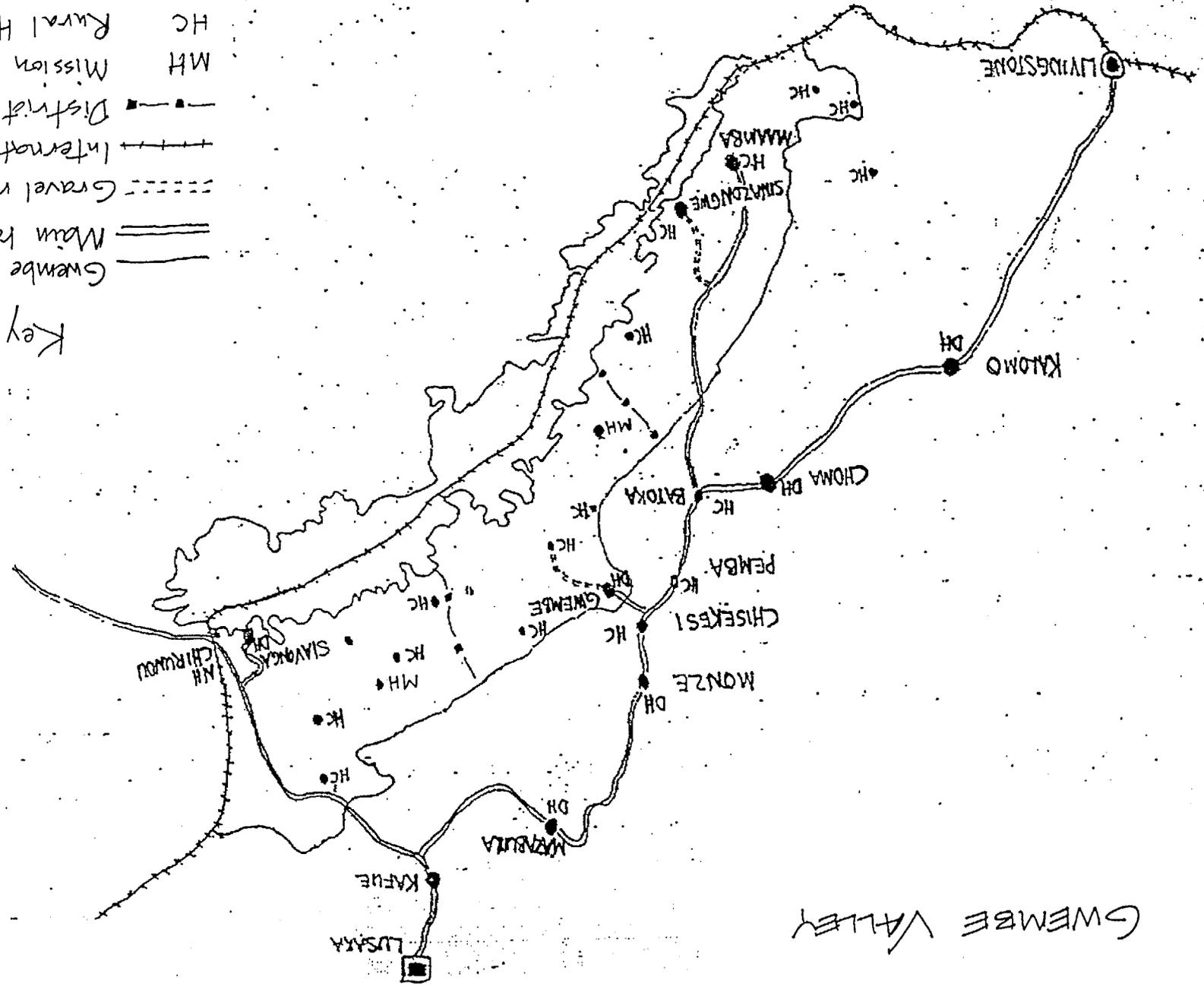


- ▨ Project Area
- Multiple urban CSAs
- ▲ Urban CSA
- Rural CSA

CSA = Census Supervisory Area



- Key
- HC Rural Health Center
 - MH Mission hospital
 - District boundary
 - International boundary
 - Gravel road
 - ==== Main road
 - ===== Gwembe Valley boundary



GWEMBE VALLEY

**GWEMBE VALLEY CHILD SURVIVAL PROJECT
HEALTH CARE INSTITUTIONS**

INSTITUTION	SERVICES RENDERED	STAFF
GWEMBE DISTRICT		
Gwembe District Hospital	Curative, HIV/AIDS Prevention, MCH: antenatal care, children's clinics/ immunization, intranatal and growth monitoring	1 Doctor 5 Nurse/midwives 1 Family Health Nurse 1 Environmental Technician
Sinafala Rural Health Centre	Preventive and curative care	1 Environmental Technician
Chabbabboma Rural Health Centre	Curative, growth monitoring, immunization, FP, antenatal care, intranatal plus postnatal	1 Psychiatric Enrolled Nurse
Chipepo Rural Health Centre	Curative care	1 Nurse/Midwife 1 Clinical Officer 1 Nurse 1 Environmental Technician
Munyumbwe Rural Health Centre	Curative care, immunization, growth monitoring, health education, FP, postnatal and intranatal care	

SINAZONGWE DISTRICT		
Sinazongwe Rural Health Centre	Intranatal, antenatal, postnatal, FP, curative care, immunization, growth monitoring	3 Enrolled Nurse/Midwives 6 Enrolled Nurses 1 Registered Nurse 1 Registered Nurse/Midwife 2 Doctors
Kafwambile Rural Health Centre	Provide first aid treatment	No trained health personnel
Siameja Rural Health Centre	Provide first aid treatment	No trained health personnel
Siatwinda Rural Health Centre	Curative, admits patients, growth monitoring, immunization, FP, postnatal/intranatal care	1 Clinical Officer 1 Enrolled Nurse/Midwife 1 Enrolled Nurse 1 Environmental Technician
Maamba Hospital	Curative, admits patients, growth monitoring, immunization, FP, antenatal/postnatal/intranatal care, health education	1 Public Health Nurse 2 Registered Nurses 6 Enrolled Nurse/Midwives 6 Enrolled Nurses 1 Environmental Technician
Sinazeze Rural Health Center	Curative, immunization, growth monitoring	1 Clinical Officer 1 Registered Nurse 1 Enrolled Nurse/Midwife
Sikaneke Rural Health Center	Provides mental health care and curative care plus health education	1 Psychiatric Enrolled Nurse
Chiyabi Rural Health Center	Antenatal/intranatal/postnatal care, growth monitoring, immunization, health education	1 Nurse/Midwife (male) 1 Environmental Technician
Sinamalema Rural Health Center	Curative care, health education	1 Enrolled Nurse

Response to Technical Review of CSXII Application: WVRD/Zambia

Concerns & Recommendations:

Concern: Project is overly ambitious and interventions are too numerous given the poor district infrastructures and limited resources. CHWs and TBAs have significant role to play but the plans for their supervision are not apparent.

Response: WV project staff concur with the fact that the original submission was too ambitious both in the size of the target population, in an extremely remote area, as well as the number of interventions. Since prior agreements with the two districts are already in place, the project was unable to change the number of districts served without damaging our relationship with these districts. Instead the project has reduced the number of outreach communities that will be served and will reach approximately half of the two districts, reducing the target population to 73,000. Unfortunately this decision was not reached prior to carrying out the KPC, so the baseline survey is based on the total population of the two districts (146,000.) The project also has reduced the number of interventions to be focused on with Nutrition and ARI no longer being a part of the project plan. Although nutrition and ARI are both significant problems in the project area, the KPC survey results and DIP process reviewing many data sources and existing resources to meet needs assisted the district and project staff to prioritize malaria, CDD, HIV/AIDS, maternal care/family planning, and EPI/UCI as the project interventions. Nutrition issues will be addressed through a joint agriculture and nutrition project to be implemented by WV-Z in Gwembe Valley which is currently in the process of being approved. The ARI component is included in the existing MOH district management plan for training in SCM for health center staff and some staff have already received training. The project will assist the district directors in making contact and establishing linkages with the BASICs project which is facilitating IMCI training which addresses ARI. The training for CHWs can be reviewed in Section E.6 and in summary, the initial training/formation takes 42 days and is based on the MOH curriculum(refresher training is once a year for one week). There will be an additional 10 CHWs per district trained per year. The existing and new CHWs will be supervised on a monthly basis by the outreach team or health center staff depending on the location of the village in which they work. The MOH is in the process of evaluating the TBA program and has limited the amount of resources which will be placed into the training of this group of individuals. The project will not train any new TBAs until a final decision has been made by the MOH and will support the existing TBAs in the project area, through facilitating the monthly supervision of the outreach and health center staff for these workers.

Concern: No apparent input or involvement of local NGO partner, community, or MOH in project development or design with top down planning reflected. Reviewers feel project is a stop gap supply initiative rather than capacity building exercise for MOH and communities.

Response: WV-Z has been working in the Gwembe Valley with communities and the MOH for the past 4 years (initial relief efforts started in 1982). The fact that WV-Z's health office is located in the MOH administrative building surely demonstrates that a strong working collaborating relationship exists. WV-Z built 2 clinics in the zone according to the defined priority, location and design plan of the MOH and communities. All CHW and TBA training under the Canadian Public Health Project which operated in the area was done with the MOH facilitators and curriculum. All outreach teams have been joint project and district health staff

CF
AS

combined and use of transport has been a collaborative effort. In the implementation of the baseline KPC survey, district health staff made up 30% of the survey team. The review and analysis of the survey and joint DIP meetings included the Chiefs of the area, District council members, and district health office representatives as well as district health center and outreach staff. Family health nurses which have been employed are retired from the MOH previously working in the district and regional MOH offices bringing a wealth of experience and knowledge regarding the strengths and weaknesses of the delivery system. Joint planning meetings have been routine between WV-Z PHC staff and the district health office. Linkages with communities are also existent given the work of the DACs (development assistance centers) of WV-Z in the districts and the previous training and continued supervision of CHWs and neighborhood committees already functioning in the area. WV-Z through this project, hopes to strengthen these relationships focusing on assisting the district health services to build stronger ties with the community and its providers. In order to facilitate the work with the communities and increase their role as project partners, the project will mobilize PLA and Gender & Development training for both project and district staff. WV-Z has also conducted meetings with the Minister of Health and Vice President of the nation both of whom propose strong support of WV-Z's work to strengthen government services and to facilitate community development. The project will also build on linkages with the local churches, mining company, women's clubs, and WV-Z agriculture and water and sanitation initiatives present in the Valley.

Concern: Objectives selected do not reflect causes of PHC problems in the target area. Should prioritize most serious problems and target for impact.

Response: Major contributors to infant and child morbidity and mortality in the project area without debate include malaria, diarrhea and malnutrition. One of the greatest constraints to reducing maternal mortality is the lack of access to facilities which can provide the essentials of obstetrical care. HIV/AIDS statistics in Zambia give great cause for concern particularly in the project area, where the ability of households taking measures to protect themselves is almost non-existent. As the project and MOH looked at resources available and the targeting of those resources within the district, decisions were made to invest the project resources to areas where the current action plan of the district MOH is not sufficient to deliver an effective response allowing for the complementarity of efforts.

Immunization

Concern: Who will give tetanus vaccine. How will health services ensure pregnant women are vaccinated? Will where UCI/EPI take place?

Response: Please see Section D.4.f for detailed plan for immunization. In summary, the project will support the district health system in delivering tetanus vaccine to WCBAs and pregnant women. Goal, 5 doses for protection for life for WCBAs and at least 2 doses before delivery for pregnant women. The vaccines services as part of the MOH plan are delivered daily from health centers and once per month from outreach health delivery points for communities which are located at distances greater than 12 km to the nearest health center. To ensure that pregnant women are vaccinated a community register is kept for follow up by CHWs and TBAs and health education messages delivered from health centers, outreach delivery points and at the village level to increase knowledge and raise awareness regarding importance, purpose and schedule for tetanus vaccine.

Diarrhea Case Management

Concern: CDD not well justified are they are a continuation of the MOH and UNICEF programs which have been implemented for many years. Need to cover local practices, resources and constraints for CDD. Review acceptance, supply and distribution of ORT. Must make sure that Staff training includes dehydration. Ensure good referral knowledge and practice for dysentery and severe diarrhea. Encourage exclusive breastfeeding to reduce episodes of diarrhea. Coordination of CDD with the water and sanitation project.

Response: Local practices regarding diarrhea have been mentioned in Section D.4b in the CDD section as well as the current acceptance (Baseline Survey results) and supply/distribution of ORT and current exclusive breastfeeding practices (Baseline Survey). The messages in the area regarding CDD have not had a strong emphasis on increase the volume intake as much as just focusing on the preparation and use of ORS packets, continued feeding and extra feeding following the diarrhea episode. The project will work with the MOH to mobilize a stronger response for home based management of diarrhea episodes at the earliest stage with an increase in fluid intake and knowledge regarding use of home available fluids and cereal based ORT. Health workers and communities will be trained in signs of dehydration and signs of dysentery and severe diarrhea and the need for immediate referral. The collaboration with the water and sanitation initiatives (also supported by UNICEF) will enhance the prevention component as the CS and water teams will work in communities together and the water program does have a education prevention component which includes water storage, handwashing, use of latrines, rubbish pits, dish racks and clean food preparation. The water project has additional plans this year for another 20 water points. The baseline KPC survey show the impact of the newly established water points as 72% of the households reported having using a protected water source. Exclusive breastfeeding (Baseline measure 87.5%) will be promoted as part of the diarrhea prevention messages.

Nutrition

Concern: Are nutrition interventions to be relief or development oriented? If relief oriented, effectiveness indicators will need to be included as well as issues of sustainability. Need to review child/infant nutrition related practices and presence of micronutrient deficiencies. Need to address the complexities of growth monitoring and supervision of community providers delivering these services. Need objective regarding growth monitoring and growth faltering and increased food supply of the community.

Response: Although, nutrition will not be a specific intervention included in the project, maternal, infant and child nutrition are the foundation of all other project efforts. The project would like to thank the reviewers for their comments which will be addressed with the ag/nutrition project design. The food security team assisting WV projects in Africa have been in dialogue regarding the Gwembe Valley and the particularities of the area and need to address some of the "root" conditions to the poor agricultural yields in the area. The agriculture/nutrition proposal was a result of the dialogue and will bring in additional resources to follow through in ensuring that nutrition initiatives are of a quality nature and given adequate attention along with a means of increasing household food security(agriculture components). Micronutrient issues will also be addressed through the ag/nutrition project. Micronutrient problems in the area include anemia related to malaria, presence of goiters with a 1993 survey showing low iodine levels - with a iodine capsule program initiated in 1994 with UNICEF funds, but later dissolved due to the

expense of the capsules. The program was then shifted to iodized salt policy for the nation. UNICEF also supported the purchase of Iodine testing kits. Vitamin A capsules according to policy are to be distributed every 6 months through the EPI/UCI program and to mothers, within 2 months following the delivery of the infant.

Pneumonia Case Management:

Concern: Details on pneumonia case management are limited with no discussion of adequacy of care seeking. Antibiotic supply appears unsure and role of community providers is unclear. No discussion of prevention measures:

Response: The ARI component is not being addressed as an intervention in the CS project, but discussions have occurred with the district health management team and with local administration representatives and health workers regarding the KPC baseline survey results and their implications for service provision and health education delivery. ARI incidence was measured at 19.6% (those with difficult or rapid breathing in the last 2 weeks. 84.9% of mothers sought medical treatment for infant/child with rapid and difficult breathing. When mothers were asked what signs/symptoms which would cause them to seek treatment for their child, they mentioned the following: 12.6% did not know, 16.7% difficult breathing, 13.3% chest indrawing, 4.8% loss of appetite, 17% fever, 45.9% cough, 14.1% groaning, 47.4% wheezing, other responses - crying, vomiting, weakness, weight loss, cough with blood.

Maternal and Newborn Care

Concern: RFA guidelines discourage using high risk indicators due to their low specificity of screening criteria. Recommend refresher training for maternal care providers with emphasis on recognition of danger signs, but difficult to detect referral cases if there is nowhere to refer to. Need to strengthen facilities and the transport to those facilities. Need to evaluate potential impact of investing in TBA initiatives as their value and outreach coverage appears somewhat limited. Need to review not only number of antenatal attenders but also the quality of services being delivered. Review family planning services available and the trend of acceptance.

Response: Please refer to Section D.4.d.3 to review the intervention plan for maternal care which focusing on early recognition and referral for danger signs (Gold Standards for Maternal Care guided plans) during the pregnancy and labor and delivery period. Refresher training in collaboration with the MCH district and regional units will be conducted for maternal care providers (midwives working at health centers and with outreach teams). In order to strengthen and upgrade a facility within the project area which can provide the essentials of obstetrical care, the amount of resources required are not available given the sum granted for the implementation of the project. Therefore, WV-Z management will make efforts to speak with other donor sources in Zambia to provide resources for the upgrading of a obstetrical care unit. The project does include an initiative to strengthen a community based/supported transport system through the local neighborhood committee as access to services in a timely fashion is a major constraint to impacting maternal mortality. TBAs are assisting an estimated 8 deliveries per year per TBA and on the baseline survey reportedly assisted 12% of the deliveries. The project will support existing TBAs as a 55% delivered with the assistance of their families and 11% assisted themselves, making the majority of the deliveries occurring in the home and access to centers having an impact on this situation. TBAs may have a role to play as they are located in the communities and would be a closer source for help if adequate training for recognition of danger signs and basic life

saving skills could be provided. Further dialogue is required at the community level to explore the current perceptions and acceptance of TBAs by the village population. The quality of prenatal services is addressed in Section D.4 under the maternal care intervention. Family planning services available and their current usage is documented in Section D.4 within the family planning intervention and the project realizes that improving services available and number of methods offered, access to these services (CBD initiatives), and need to involve men in the education of messages and understanding of services available.

HIV/AIDS

Concern: Need to mention current interventions in the area and current levels of knowledge among population regarding HIV/STD issues. Need greater percent of project effort - 5% means nothing - might mean project has too many activities to address and quality or impact will be sacrificed. Should consider HIV/AIDS education within maternal care and family planning services/interventions. Consider inviting Anti-AIDS clubs of Zambia to expand activities in the Valley.

Response: Section D.4 HIV/AIDS intervention section covers the current activities in the project area related to HIV/AIDS. The percent of project effort has been increased and three objectives have been set which target involving men and increasing men and women's ability to take measures to protect themselves against HIV/AIDS. HIV/AIDS education will be included in the prenatal and child spacing activities as there is great effort to encourage integration of reproductive health services not just with involvement of women but much more the involvement of couples/households. The Anti-AIDS clubs of Zambia are a practiced drama group which is based out of Lusaka and travels around the country making drama performances which must be financed. The project feels that the talent among the local people, staff and school children which can be applied to the creation of dramas and messages related to the prevention and awareness of HIV/AIDS in the Gwembe Valley has great potential and is a more appropriate strategy and option.

Malaria

Concerns: What is the status for care seeking - is education needed? What is the chloroquine resistance in the area. What are the treatment protocols?

Response: Malaria is a well known condition in the Valley for which medical treatment is readily sought (KPC baseline survey - 82% of the mothers sought care for their child who was suffering with malaria in the 2 weeks prior to the survey.). The issue of care seeking has always come down to access to care as many villages are located over 12 km from the nearest health post and this is where the CHWs ability to properly provide first line treatment for acute episodes of malaria and refer individuals experiencing complications can be of great value. Resistance to chloroquine has been a problem in the area (see Malaria Intervention Section D.4.a) and there is great need at all levels of care to spend time with individuals as treatment is being provided to reinforce the need to complete the treatment protocol. WV does not have its own treatment protocol, but observes that of the MOH which is spelled out in Section D.4.a.

Human Resources

Concern: With involvement and support for transport, need to consider spare parts and training for operation, maintenance, and basic repairs. Should establish policy regarding ownership,

operator usage, responsibilities and eligibility for spare parts and fuel.

Response: The project in collaboration with the district has made a decision not to purchase motorcycles for assistance in outreach service delivery or supervision. One reason this decision was made, was related to the fact that the road terrain is very rough and deteriorates even further during the rainy season, making it challenging even with a 4WD. There will be an agreement established between WV-Z and the MOH regarding use of the vehicles and sharing of fuel costs and what activities and services will be given priority. The drivers which have been hired for the project are also mechanics. The MOH does conduct workshops for district ambulance drivers on the maintenance of vehicles. Seeing that bicycles will be used for the CHW work, the above issues of ownership, responsibilities, spare parts, etc. will be addressed and carefully reviewed with the CHWs before the bicycles are provided.

Sustainability

Concern: Consider adding some indicators to track sustainability.

Response: Sustainability goals have been set with objectives by which those goals will be measured and activities by which the objectives will be achieved and can be reviewed in Annex . Also, WV in the region has been making use of a "Sustainability Readiness Index" which is a tool which involves the project, MOH and community in addressing issues of sustainability and service value. This SRI tool will be used in year 3 of the project period.

HEALTH SECTOR REFORM: ZAMBIA (1996)

Objective of the Reforms:

To provide Zambians with equity of access to cost effective, quality health care as close to the family as possible to be realised through a radical overhaul of the health care system.

Principles of the Reforms:

leadership

accountability

partnership

These principles are translated into the following important features:

a goal oriented, financially sound management system of health care

clear accountability and responsibility at every level

a mechanism for regular review of progress

enhanced role and responsibility of consumers

strengthened health center-supported community-based health care

maintenance of the roles of public hospitals including psychiatric and teaching hospitals

integration of private sector strengths and resources

improved quality assurance and treatment effectiveness

broadened range of professionally regulated health providers

HEALTH SECTOR REFORM: ZAMBIA (1996)

Decentralisation

Decentralisation is at the center of the reforms. The following changes were achieved since 1992:

Structural Changes

Central level

1. Ministry of Health

to be transformed to a policy-making and advisory institution.

[Health Reform Implementation Team]

2. Central Health Board and its Secretariat

will be responsible for implementing the technical work of the MOH

will oversee and guide the decentralisation process

Regional offices of the CHB will provide quality support for technical and managerial problems to the District

HEALTH SECTOR REFORM: ZAMBIA (1996)

District level

District Health Boards

1. Help and support district health management teams--
not to implement services

ensures that the DHMT performs its duties according to its guidelines

sees that plans submitted by the DHMT take into consideration the priorities identified by the health center and neighbourhood committees

2. Review and transmit district health budgets
3. Deal with staff matters locally, even hiring and firing

District Health Management Team.

1. Prepare district health plan and budget
2. Manage the implementation of health services in the district
3. Initiate and promote partnership with other providers and sectors in the District,
4. Manage personnel
5. Monitor and evaluate

HEALTH SECTOR REFORM: ZAMBIA (1996)

Health Center Committee

1. Consolidate community needs
2. Initiate and support activities in the community including the community-based volunteers
3. Mobilise and account for resources
4. Contribute to the upkeep and security of the health centers

Neighbourhood Committees

1. Be the linkage between community health center staff the community
2. Develop mechanism for supporting and sustaining community-based health volunteers
3. Collect relevant community based data
4. Initiate and participate actively in health-related activities at household and neighbourhood level.

Autonomous Hospital Boards (15 govt. and 5 mission hospitals):

1. Set up for hospitals with more than 200 beds
2. Operate separately from district health boards
3. Have their own budget (they are, however represented on DHB and DHMT)

HEALTH SECTOR REFORM: ZAMBIA (1996)

Financial Decentralisation

Allocation to the health sector increased from 5.7% in 1991 to 13.4% in 1994 and kept at that level since then.

increasing share of the total health care budget allocated to primary care from 29% in 1992 to 47% in 1996;

having the districts draw up their annual plans and budgets with the contribution and involvement of health centers and neighbourhood committees;

devolving the spending authority in all districts down to the level of health centers;

instituting user fees and prepayment fees. In some health centers, the level of the fee to be charged is decided with the participation of the neighbourhood committees and proceeds used at point of collection;

training for staff at all levels to use the instruments designed for fiscal responsibility and accountability.

Mode of Financing

Basket Funding

Donor support by financing a single agreed budget administered by the Ministry of Health.

Not all donors are willing to be part of this system because some skepticism remains that the funds will be used for what they are meant; others are finding ways to join without contravening their own reporting system.

HEALTH SECTOR REFORM: ZAMBIA (1996)

Some General Comments

The spirit behind the reforms is the Hon. Minister, Dr. Katele Kalumba; it is his vision, and he is providing effective leadership.

It seems the political and social climate in Zambia and the availability of the technical capacity in the country have come together at the same time to make the reforms possible.

Whilst we were there, the elections were imminent and there was a rush by the Hon. Minister to set up the outstanding health boards in the nation's 57 districts; at the same time, the health policy consultant was recommending that devolution to the districts be slowed down until certain conditions were fulfilled. Kalumba knew this chance to set them up may never come again.

Not all the districts are at the same level of development; financial reforms are the most advanced.

Composition of the Boards seems to favour the elite, the same persons who were the beneficiaries of the old system. There is need for representation from the 'grassroots'.

The reforms are being implemented from the MOH downwards towards the community. There is a consensus that in most districts, it has gone as far as the health centers, and it needs to be pushed on into the community--villages, neighbourhoods, health posts; this is where the transformation must take place for the reforms to have any effect on health status.

The Six Health Thrusts

Safe Motherhood and Family Planning
Child Health and Nutrition
Malaria
Water and Sanitation
Tuberculosis
HIV/AIDS

Primary Health Care includes

- ☛ **Curative Care**
e.g., Integrated Management of Childhood Illnesses
- ☛ **Preventive Care (or Prevention)**
e.g., Vaccinations, Personal Hygiene
- ☛ **Promotive Care**
e.g., Health Promotion and Education
Environmental Management



EHP Objectives

Overall Objective: *Reduce diarrhea and malaria rates for children under five in target communities.*

EHP will work with the DHMT to:

- 1) Establish and maintain baseline information for monitoring of interventions
- 2) Reduce community-identified high-risk behaviors in target communities
- 3) Reduce community-identified high-risk environmental conditions in target communities
- 4) Develop district and local planning and implementation capacity to sustain interventions
- 5) Develop effective collaboration with all stakeholders
- 6) Develop effective coordination of Cooperating Agencies (CAs)

Community Training, Assessment and Planning (CTAP)	
Phase 1: Develop district capacity for CTAP	
Phase 2: Identify Partners and Build Partnerships	
Phase 3: Select Emphasis Behaviors	These are the four phases of Community Assessment and Planning which ZCH is currently using in Zambia
Phase 4: Explore Reasons for the Behaviors	
Phase 5: Develop Intervention Strategies	
Phase 6: Implement and monitor Interventions and Microprojects	

Community Training, Assessment and Planning (CTAP)

PHASE 1: DEVELOP DISTRICT CAPACITY FOR CTAP

- identify and develop capacity of a district training team
- develop IEC and training approaches
- select emphasis behavior menu for Kitwe
- determine survey and sampling methodologies to be used

PHASE 2: IDENTIFY PARTNERS & BUILD PARTNERSHIPS

- build working relationships between health staff & community
- train neighborhood health committees in the six health thrusts emphasis behaviors, and CTAP

PHASE 3: SELECT EMPHASIS BEHAVIORS

- conduct household and community surveys with NHCs to identify existing behaviors and environmental conditions
- establish/expand baseline information
- rank unacceptable behaviors by focus group discussions
- select 3-5 priority behaviors from the emphasis behaviors

PHASE 4: EXPLORE REASONS FOR THE BEHAVIORS

- develop better understanding of the selected behaviors
- explore possible changes in behavior environmental conditions

PHASE 5: DEVELOP INTERVENTION STRATEGIES

- identify resource needs- community-based and partnerships
- allocate responsibilities to the community and health facility
- identify indicators and monitoring procedures

PHASE 6: IMPLEMENT AND MONITOR INTERVENTIONS

- initiate community-managed microprojects and partnerships
- monitor and Evaluate Indicators
- feedback to the District CTAP team

**WATER AND SANITATION COLLABORATION W/UNICEF AND
LOCAL GOVERNMENT**

NGO/PVO/DONOR	ACTIVITIES	COLLABORATION WITH WV-Z
UNICEF	Drilling boreholes, rehabilitation of water sources	UNICEF funded the project and seconded a Water Engineer to the project
Council (local government) Gossina Water Aid	Drilling boreholes in specific communities within Gwembe Valley, training for village WASHE committees.	WV-Z together with these NGOs are part of the WASHE District Team for planning and implementation of the programs.

MINISTRY OF HEALTH
ANTE-NATAL CARD

NAME OF CLINIC _____
Registration No. _____
NAME _____
Address _____
Age _____
Name of husband/next of kin _____
Height _____
Bloodgr. _____ Rh. _____

OBSTETRIC HISTORY
No. of pregnancies _____ No. of live births _____
No. of abortions _____ No. living children _____
No. of stillb. _____ No. dead children _____
History of TB _____

No.	PREGNANCIES		Mode of delivery	CHILDREN	
	Year	Duration pregnancy		Birth weight	Alive/Dead at birth
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

FIRST VISIT

RISK FACTORS AND EXAM

LMP _____ EDD _____
RPR _____

RISK FACTORS

- Younger than 16 years _____ Tick
- Older than 35 years _____
- > 10 years since last pregnancy _____
- Height under 150 cm _____
- Deformities or paralysis (specify) _____
- 6 or more pregnancies _____
- Last delivery vacuum/forceps _____
- Previous caesarian section _____
- Third stage complication (e.g. PPH) (specify) _____
- Previous stillbirth _____
- Previous neonatal death _____
- > 2 previous abortions _____
- Serious illness (specify) _____

EXPLANATION

Hospital delivery is indicated
Refer to doctor for control
Refer to hospital immediately

EXAMINATIONS

Pelvic exam: _____

Doctor's exam: _____

REMARKS

POSTNATAL PERIOD

Date of delivery _____ / _____ / 1999
Date of discharge _____ / _____ / 1999
Place of mode of delivery _____
Postnatal comp _____

MOTHER (on discharge)

Urine _____ Anaemia _____
Breast _____
Puerperium _____
Advice on child spacing given _____
General condition on discharge _____

BABY (on discharge)

Birth weight _____
Discharge weight _____
Method of feeding _____
Neonatal complications _____
Remarks _____
Did baby get under five card and BCG? Y/N _____

POSTNATAL VISIT Date _____ / _____ / 1999

Complaints _____
Symptoms _____
Duration of bleeding _____
Method of feeding _____
BP _____ Urine _____
Abdomen _____
Vaginal examination if necessary _____
General condition _____
Treatment or advice _____
Child spacing _____

C4W3

PRIMARY HEALTH CARE REVIEW FORM

NAME OF C.H.V. HEALTH POST DATE

VILLAGE YOU COVER POPULATION WHERE DELIVERED MONTH

NO. OF DEATHS CAUSES OF DEATH SUPERVISING R.E.

CHILDREN 0-5 6-15 ADULTS M F M

1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.	18.	19.	20.
VILLAGE VISITED THIS MONTH		NO. OF HOUSES VISITED	LATRINES DUG	USED	UNDER CONSTRUCTION	WATER SUPPLY PROTECTED	SHAL/WELL	RIVER DAM	B/HOLE	OTHER	INDENOURISHED CHILDREN	AGE	STATUS	WHO REFERRED	TO WHOM				
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

DATE HEALTH COMMITTEE H.L.D. 19.....

ASSENT 1.

NAME 2.

MEMBERS 3.

4.

5.

6.

MONTHLY RETURN FOR T.B.A

NAME OF R.H.C.:

NAME OF HEALTH POST:

NAME OF T.B.A.:

MONTH:

ANTE-NATAL

NEW CASES:

OLD CASES:

REFERRED TO HOSPITAL OR R.H.C.

ABORTIONS:

NORMAL DELIVERIES

MALE: ALIVE: DIED:

FEMALE: ALIVE: DIED:

REFERRED TO HOSPITAL/RHC FOR DELIVERY:

POST NATAL

NEW CASES:

REFERRED TO HOSPITAL/RHC:

No. HOME VISITS:

No. VILLAGES VISITED:

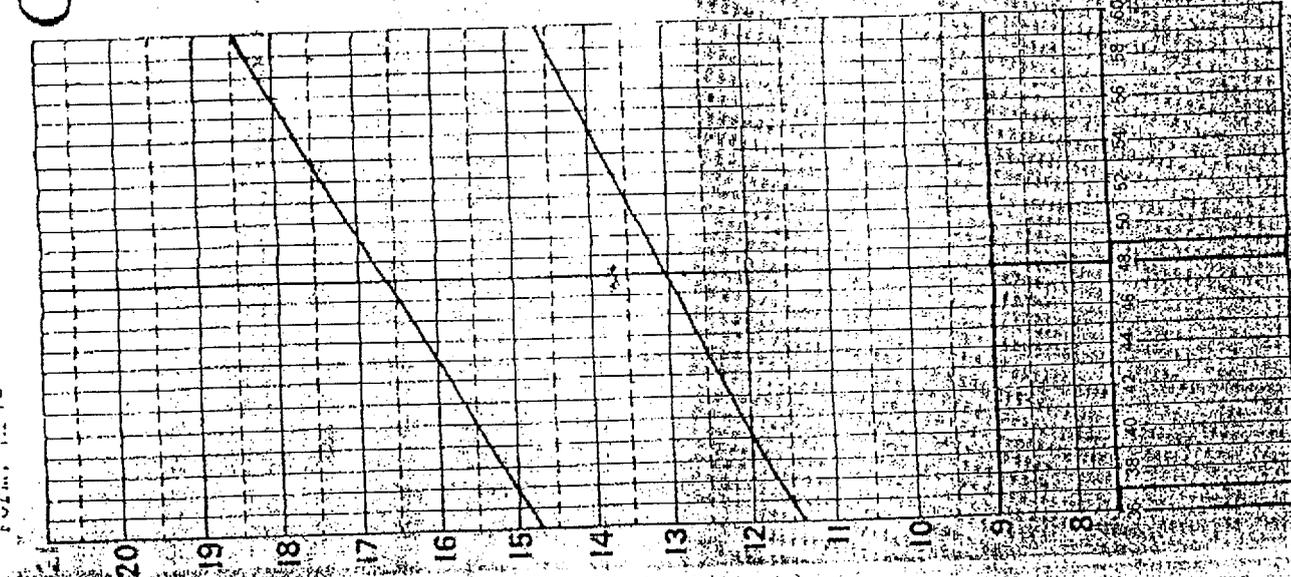
ANTE-NATAL AND CHILDREN'S CLINIC

PRESENT AT CHILDREN'S CLINIC YES/NO

PRESENT AT ANTE-NATAL CLINIC YES/NO

No. OF VISITS TO CHILDREN'S CLINIC:

No. OF VISITS TO ANTE-NATAL:



3-4 years 4-5 years

Children's Clinic Card

Clinic	Child's no.
Child's name	Boy/Girl
Mother's name	Registration No.
Father's name	Registration No.
Date first seen	Birthday-birthweight
Where the family lives: address	

BROTHERS AND SISTERS	
Year of birth	Remarks
Boy/Girl	

IMMUNISATION RECORDS

IMMUNISATION AGAINST TUBERCULOSIS (TB)

PCG (at birth)

IMMUNISATION AGAINST POLIO

OPV 1 (at 2 months) Date: _____

OPV 2 (at least 4 weeks after OPV 1) Date: _____

OPV 3 (at least 4 weeks after OPV 2) Date: _____

OPV Booster (at least 1 year after OPV 3) Date: _____

IMMUNISATION AGAINST WHOOPING COUGH, TETANUS AND DIPHTHERIA

DPT 1 (at 2 months) Date: _____

DPT 2 (at least 4 weeks after DPT 1) Date: _____

DPT 3 (at least 4 weeks after DPT 2) Date: _____

DPT Booster (at least 1 year after DPT 3) Date: _____

IMMUNISATION AGAINST MEASLES

MEASLES (9 months of age or soon after) Date: _____

SCHOOL IMMUNISATIONS

OTHER IMMUNISATIONS

TALLY SHEET FOR MCH-TEAMS TO RECORD IMMUNIZATIONS PERFORMED

EPI 1

	STATIC: <input type="checkbox"/> PERIOD COVERED FROM:	OUTREACH:										TOTAL <1 TOTAL >1	
							TO:						
BCG	<1	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
	>1	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
DPT 1	<1	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
	-	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
	>1	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
DPT 2	<1	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
	>1	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
DPT 3	<1	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
	>1	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
Booster DPT		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
OPV 1	<1	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
	>1	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
OPV 2	<1	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
	>1	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
OPV 3	<1	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
	>1	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
Booster OPV		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
MEASLES	<1	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
	>1	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
FULLY VACCINATED	<1	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
	>1	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
TOTAL P - TOTAL W													
TT 1 P		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
TT 1 W		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
TT 2 P		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
TT 2 W		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
TT 3 P		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
TT 3 W		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
TT 4 P		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
TT 4 W		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
TT 5 P		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
TT 5 W		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		
		00000	00000	00000	00000	00000	00000	00000	00000	00000	00000		

KEY: <1 = children under 1 year, >1 = children above 1 year. P = pregnant mothers, W = women of childbearing age
 NOTE: Mark date on top of tally sheet when you start using it and also when you close it.

TALLY SHEET FOR MCH--TEAMS TO RECORD
 NUMBER OF CASES AND DEATHS DUE TO EPI DISEASES

EPI 2

PERIOD COVERED FROM: TO:

CASES			TOTAL	DEATHS			TOTAL
V	N	NK		V	N	NK	

MEASLES

<5 YEARS	00000	00000	00000	00000	00000	00000		000000	000000	000000	000000	000000	000000
	00000	00000	00000	00000	00000	00000		000000	000000	000000	000000	000000	000000
	00000	00000	00000	00000	00000	00000		000000	000000	000000	000000	000000	000000
TOTAL													
<5 YEARS	00000	00000	00000	00000	00000	00000		000000	000000	000000	000000	000000	000000
	00000	00000	00000	00000	00000	00000		000000	000000	000000	000000	000000	000000
	00000	00000	00000	00000	00000	00000		000000	000000	000000	000000	000000	000000
TOTAL													

NEONATAL TETANUS

<1 MONTH	00000	00000	00000	00000	00000	00000		000000	000000	000000	000000	000000	000000
	00000	00000	00000	00000	00000	00000		000000	000000	000000	000000	000000	000000
TOTAL													

POLIOYMELETS

<5 YEARS	00000	00000	00000	00000	00000	00000		000000	000000	000000	000000	000000	000000
	00000	00000	00000	00000	00000	00000		000000	000000	000000	000000	000000	000000
TOTAL													
<5 YEARS	00000	00000	00000	00000	00000	00000		000000	000000	000000	000000	000000	000000
	00000	00000	00000	00000	00000	00000		000000	000000	000000	000000	000000	000000
TOTAL													

Key: V - Vaccinated. N - Not Vaccinated. NK - Vaccination status not known

NOTE: Do not forget to write dates on top of tally sheet
 to mark when recording starts and ends.

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**UCI MONTHLY REPORTING FORM FOR HEALTH FACILITIES ON
IMMUNIZATIONS PERFORMED (STATIC AND OUTREACH) AND STOCK CONTROL EPI 3**

HEALTH INSTITUTION: YEAR: MONTH:

	BCG	DPT1	DPT2	DPT3	BD	OPV1	OPV2	OPV3	BO	MEAS	FV	TT1	TT2	TT3	TT4	TT5
<1 - static																
- outreach																
TOTAL																
>1 - static																
- outreach																
TOTAL																
P - static																
- outreach																
TOTAL																
W - static																
- outreach																
TOTAL																

VACCINE SUPPLIES	BCG	DPT	OPV	MEASLES	TT
Vaccine brought forward (A)					
Vaccine received this month (B)					
Vaccine used and wasted (C)					
Vaccine in stock (D)					

Key: < 1 - Children under 1 year, > 1 - children above 1 year, BD - Booster DP1, BO - Booster OPV.
FV - fully vaccinated, P - Pregnant mothers, W - women of childbearing age
Note: The amount of vaccines should be recorded in doses.

OTHER SUPPLIES		Amount brought forward (A)	Amount received during month (B)	Amount used/discarded during month (C)	Present stock D
Item					
Syringes -0.5ml					
-0.1ml					
- other					
Needles -22 gauge					
-26 gauge					
- other					
Paraffin					
Spare parts (Ref)	Specify				
Spare parts (other)	Specify				
Immunization cards					
TT cards					
Other	Specify				

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EPI MONTHLY REPORTING FORM FOR HEALTH FACILITIES ON
 MORBIDITY AND MORTALITY

EPI 4

AND GENERAL INFORMATION
 HEALTH INSTITUTION: YEAR: MONTH:

DISEASE	CASES			TOTAL	DEATHS			TOTAL
	V	N	NK		V	N	NK	
MEASLES <5years								
<5years								
TOTAL								
NEONATAL TETANUS <1 months								
TOTAL								
POLIOMYELITIS <5years								
>5years								
TOTAL								

Key: V-vaccinated N- not vaccinated NK - vaccination status not known
 Note: If nocases occurred, write 0, do not leave blank spaces.

PRESENT STAFFING AT HEALTH FACILITY		Participates in UCI
Name	Designation	

Outreach carried out during month: Yes No If yes, how many times:

Number of places visited: Yes No

Transport available: Yes No If yes, specify:

Equipment	Total number	Working No.	Remarks
vaccine carrier			
steam sterilizer			
thermometer			
primus stove			
refrigerator			

Problems, comments:

NAME OF OFFICER:
 SIGNATURE:
 DESIGNATION: DATE FORWARDED:

Remember: A copy of EPI 3 & 4 should be sent each month to district coordinator.

DIARRHOEA TREATMENT CHART

HOW TO ASSESS YOUR PATIENT

	A	B	C	D
1. ASK ABOUT: DIARRHOEA	Less than 4 liquid stools per day	4 to 10 liquid stools per day	more than 10 liquid stools per day	Longer than 3 weeks duration (chronic diarrhoea) blood or mucus in the stool
VOMITING	None or a small amount	Some	Very frequent	
THIRST	Normal	Greater than normal	Unable to drink	
URINE	Normal	A small amount, dark	No urine for 6 hours	
2. LOOK AT: CONDITION	Well, alert	Unwell, seepy or irritable	Very sleepy, un-conscious, floppy or having fits	Severe undernutrition
TEARS	Present	Absent	Absent	
EYES	Normal	Sunken	Very dry and sunken	
MOUTH AND TONGUE	Wet	Dry	Very dry	
BREATHING	Normal	Faster than normal	Very fast and deep	

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3. FEEL: SKIN	A pinch goes back quickly	A pinch goes back slowly	A pinch goes back very slowly	
PULSE	Normal	Faster than normal	Very fast, weak, or you cannot feel it	
FONTANELLE (in infants)	Normal	Sunken	Very sunken	
4. TAKE TEMPERATURE				High fever – 38 degrees Centigrade or 101 degrees F/h.
5. WEIGH IF	No weight loss during diarrhoea	Loss of 25–100grms for each kg of weight	Loss of more than 100grms for each kg of weight	
6. DECIDE	The Patient has no signs of dehydration	If the patient has 2 or more of these signs, he has some dehydration	If the patient has 2 or more of these danger signs he has severe dehydration	If the patient has chronic diarrhoea, severe undernutrition, or high fever, treat or refer to.....for treatment. If there is blood or mucus in the stool and high fever suspect dysentery and treat with antimicrobials
	USE PLAN A	USE PLAN B	USE PLAN C	

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11/19
2-7

TREATMENT PLAN A

TO PREVENT DEHYDRATION

EXPLAIN TO THE MOTHER HOW TO TREAT DIARRHOEA AT HOME FOLLOWING THREE RULES:

- 1. GIVE YOUR CHILD MORE FLUIDS THAN USUAL, such as:**
 - rice water, fruit juice, weak tea, or salt and sugar solution and
 - breast milk, or milk feeds mixed with equal amounts of water
- 2. GIVE YOUR CHILD FOOD:**
 - as much as he wants
 - 5 to 7 times a day
 - which is easy to digest
 - which contains potassium
- 3. WATCH FOR SIGNS OF DEHYDRATION, (You must show the mother how to ASK, LOOK AND FEEL for the signs. Then ask her to show you.) BRING YOUR CHILD BACK, IF:**
 - you see any signs
 - your child has diarrhoea for another two days

TELL THE MOTHER THESE RULES ARE IMPORTANT. EXPLAIN THAT SHE CAN PREVENT DIARRHOEA, IF:

- she gives her child fresh, clean and well-cooked food and clean drinking water
- she practices good hygiene

SHOW THE MOTHER HOW TO PREPARE AND GIVE ORS SOLUTION AT HOME, IF:

- her child has been on Plan B
- It is national policy to give ORS solution to all children who visit a health centre for diarrhoea treatment
- the mother cannot come back if the diarrhoea gets worse

GIVE THE MOTHER ENOUGH ORS PACKETS FOR 2 DAYS

AFTER EACH LOOSE STOOL, TELL HER TO GIVE:

- 50-100 ml (¼-½ cup) of ORS solution for a child less than 2 years old
- 100-200 ml for older children. Adults can take as much as they want

If the child vomits, tell her to wait 10 minutes and then continue slowly giving small amounts.

NOTE: Children being given ORS solution should not also receive salt and sugar solution.



WORLD HEALTH ORGANIZATION

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TREATMENT PLAN B TO TREAT DEHYDRATION WITH ORS SOLUTION

1. USE THIS TABLE TO SEE HOW MUCH ORS SOLUTION IS SUITABLE FOR 4-6 HOURS TREATMENT:

Patient's weight In kilograms	3 5 7 9 11 13 15 20 30 40 50						
Patient's age *	← months →			← years →			
Give this much solution for 4-6 hours	in ml:	200-400	400-600	600-800	800-1000	1000-2000	2000-4000
	in local unit of measure:						

* Use the patient's age only when you do not know the weight.

If the patient wants more ORS solution, give more. If the eyelids become puffy, stop and give other fluids. Use ORS solution again when the puffiness is gone.

If the child vomits, wait 10 minutes and then continue slowly giving small amounts of ORS solution.

2. IF THE MOTHER CAN REMAIN AT THE HEALTH CENTRE

- tell her how much ORS solution to give her child
- show her how to give it
- watch her give it

3. AFTER 4-6 HOURS REASSESS THE CHILD. THEN CHOOSE THE SUITABLE TREATMENT PLAN.

NOTE: FOR CHILDREN UNDER 12 MONTHS CONTINUING TREATMENT PLAN B AFTER 4-6 HOURS, TELL THE MOTHER TO GIVE:

- breast milk feeds between drinks of the ORS solution, or
- 100-200 mls of clean water before continuing ORS if she does not breast feed her child

4. IF THE MOTHER MUST LEAVE ANY TIME BEFORE COMPLETING TREATMENT PLAN B, TELL HER:

- to finish the 4-6 hour treatment as in 1. above
- to give the child as much ORS solution as he wants after the treatment
- to look for the signs of dehydration and, if the child has any, to return the next morning

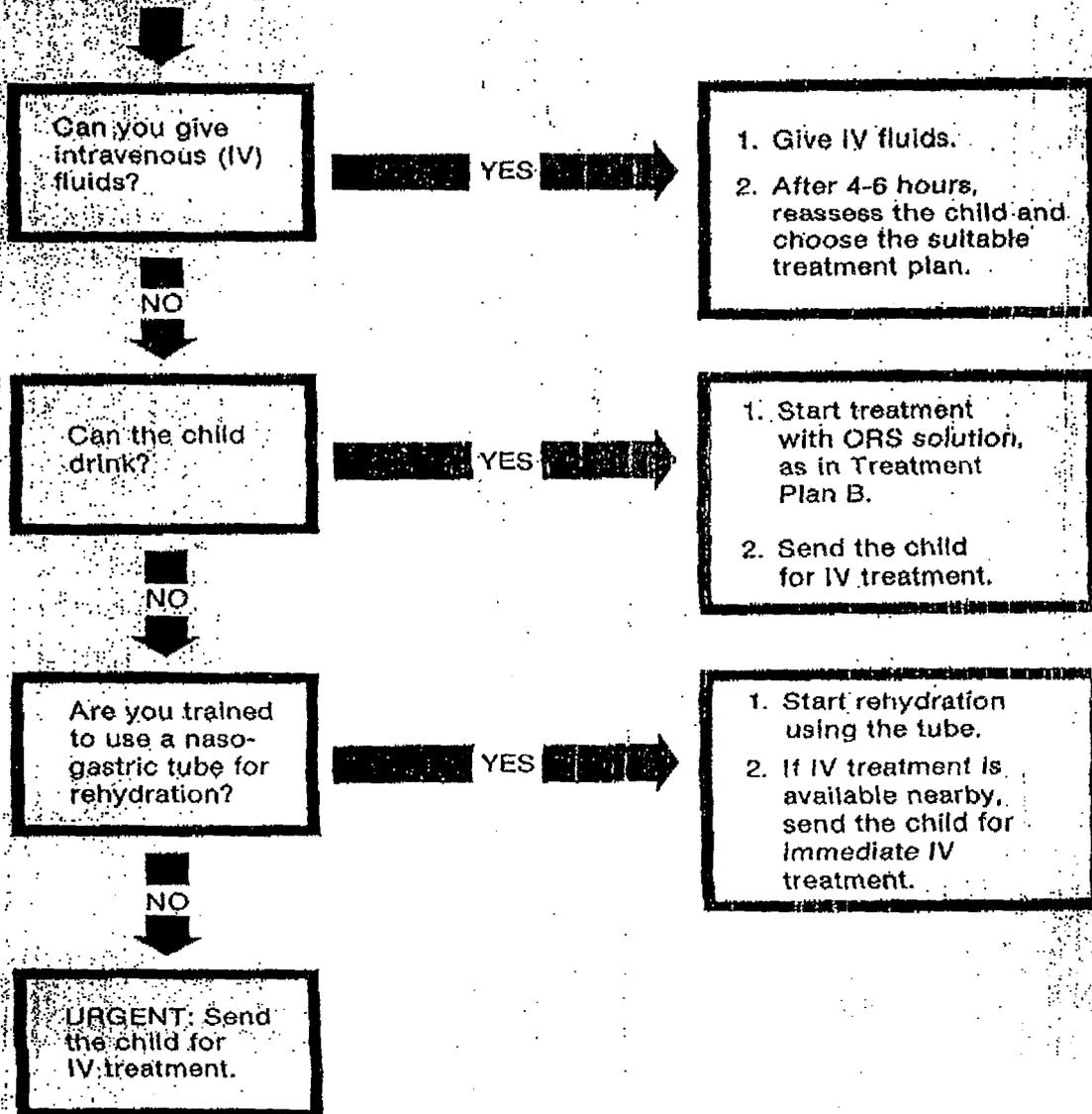
Give her enough ORS packets for 2 days and show her how to prepare ORS solution.

Explain briefly how to prevent diarrhoea.

TREATMENT PLAN C TO TREAT SEVERE DEHYDRATION QUICKLY

Follow the arrows. If the answer to the questions is 'yes', go across. If it is 'no', go down.

START HERE



NOTE: If there is a high fever, show the mother how to cool the child with a wet cloth and fanning.

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TREATMENT PLAN D DYSENTERY

First Choice: Naladixic Acid, 500 mg 4x/day for 5-7 days
Second Choice: Tetracycline Capsules, 500 mg 4x/day for 5-7 days

L-6

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PROTOCOL FOR MALARIA TREATMENT

Annex M

First Line Treatment

Chloroquine Tablets

Adult	15 years and above	4	4	2
Children	10-14 years	3	3	1½
	5-9 years	2	2	1
	1-4 years	1	1	½
	Less than one year	½	½	¼
		or 10mls	10mls	5mls syrup

Second Line Treatment

Fansidar Tablets

Adults	15 years and above	3 stat
	30-40 kg body weight	2 stat
	20-30 kg	1½ stat
	10-20 kg	1 stat
	5-10 kg	½ stat
	Less than 5 kg	¼ stat

Third Line Treatment

Quinine Tablets

Adults 600 mg tablets, one per day/7 days

Acute and/or cerebral malaria

Loading dose: 20 mg per kg body weight IV in 5% dextrose in 4hrs. Subsequent 5 doses 10 mg per kg body weight IV every 8 hours.

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REPUBLIC OF ZAMBIA
 MINISTRY OF HEALTH
 FAMILY PLANNING SERVICE MONTHLY ACTIVITY RECORD

Completed : NAME: _____ POSITION: _____
 HEALTH FACILITY _____
 DISTRICT _____

Total No. of Health Facilities:
 No. Facilities providing FP:
 No. of Facilities reporting :

month..... year.....

1		2	3	4	5	6		7	8	9		10
BRAND/ METHOD		BALANCE FROM PREVIOUS MONTH	SUPPLIES ORDERED	SUPPLIES RECEIVED THIS MONTH	TOTAL AVAILABLE (2+4)	QUANTITIES ISSUED		TOTAL ISSUED 6A+6B	STOCK BALANCE	NO. OF ACCEPTOR		REMARKS
Type/Brand	UNIT OF measure					UNITS USED 6(A)	TRANSFERR / RECEIVED 6 (B)			NEW	CONTINUE	
MICROGYNON	CYCLE											
EUGYNON	"											
NEOGYNON	"											
NORDETTE	"											
MICROVAL	"											
MICROLUT	"											
LO - FEMINAL	"											
CONDOMS	PIECE											
FOAMING TABLETS	TABLETS											
COPPER T380 A	LOOP											
FOAMS (specify)	CAN											
DIAPHRAGM	PIECE											
JELLIES (specify)	TUBE											
NPF	KIT											

Strategic Plan, 1994-1998

SECTION III: POLICY GUIDELINES FOR NATIONAL PREVENTION AND CONTROL OF HIV/AIDS/STD IN ZAMBIA**3.1 AIDS/STD National Programme in the context of general policy guidelines**

To curb an epidemic which will have such impact on every sector of society. There is need to develop policy guidelines that will address the various facets of the AIDS epidemic.

3.2 Policies for selected strategies and interventions for the prevention and the control of AIDS/STD in Zambia

- a) The NACP will stimulate and facilitate general policy development for the prevention and control of AIDS/STD in various sectors. This is in recognition of the fact that AIDS will continue to have impact on the various sectors. Therefore, development of policy guidelines is critical to the actual prevention and coping with AIDS.
- b) The Ministry of Health in conjunction with Ministry of Education and key NGOs will evolve policies for the prevention and control of AIDS/STD for the youth in school and out of school.
- c) Consistency in messages and methods in Health Education and Health Education policy for AIDS/STD prevention shall be developed in Zambia.

3.3 Policies for reducing impact of AIDS on the individual

- a) The NACP will commission a study to review existing legal instruments and how they relate to the prevention and control of HIV/STD in Zambia and suggest possible amendments to support HIV/STD prevention in Zambia.
- b) A review of the legal rights of AIDS patients and HIV positive individuals with a view of developing specific legislature that guarantees such rights.
- c) A review of the inheritance laws of Zambia to ensure that survivors of the epidemic (i.e. orphans, widows and widowers) receive their share of property.
- d) A review of the present loan/credit facilities as they relate to women and the disadvantaged.
- e) A review of property ownership as it relates to women.
- f) The NACP will develop comprehensive care policy for AIDS patients which will include the following measures:
 - i) Strengthening of the present system of care for HIV, centered on health centers and home care.
 - ii) Review the existing referral system.
 - iii) Review the existing supervisory system for quality care.
 - iv) Review existing mechanisms for collaboration and coordination of various home care groups.
 - v) Review the present death certification and burial arrangements for patients who die at

- vi) home.
Define cost-effective home care strategies.

3.4 Policies for Reducing Impact of AIDS on the Family

NACP has commissioned a study to review the problems and needs of survivors of AIDS. On the basis of these findings NACP will develop policies which will form the basis for providing support for survivors in liaison with the Ministry of Social Community Development and Social Welfare.

3.5 Policies for Reducing Impact of AIDS on the Community

The Ministry of Health in conjunction with Ministry of Community Development and Social Welfare will develop policies which will mitigate the impact on the community. To be included in this policy:

- a) a general assessment of the present community coping mechanisms and resources through participatory research approaches.
- b) provide technical support for communities to strengthen existing community coping mechanisms.
- c) indicate possible cost-effective options for dealing with AIDS patients and their families.

3.6 Policies in Relation to National Socio-economic Issues in Zambia

NACP has commissioned a number of studies that will look at the potential short and long term impact of AIDS on key sectors of the economy. Using the information obtained NACP will evolve policies to advise the Government and the private sector on how to mitigate this impact.

3.7 Development of Standard Guidelines for Carrying out Interventions at all Levels

To facilitate the development of district specific interventions in prevention and control of AIDS/STD NACP will develop the following:

- a) A standard manual for district planning for HIV/AIDS & STD.
- b) Guidelines for monitoring activities at the district level.
- c) Revise the present reporting system.
- d) Introduce AIDS quarterly reporting system as from 1994 January.
- e) Formats for reporting on AIDS activities with a schedule for such reports.

S.T.D. MONTHLY REPORT MONZE DISTRICT

CENTRE	MONTH		19
	MALE	FEMALE	
GONORRHOEA			
CHANCROID			
NON SPECIFIC GENITAL ULCERS			
NON SPECIFIC URETHRITIS			
NON SPECIFIC VAGINITIS			
LYMPHO GRANULOMA VENEREUM			
HERPES GENITALIS			
TRICHOMONAS VAGINALIS			
CANDIDIASIS			
PRIMARY SYPHILIS			
SECONDARY SYPHILIS			
GRANULOMA INGUINALE			
GENITAL WARTS			
BALANOPOSTHITIS			
VENEROPHOBIA			
OTHERS			
R.P.R. DONE			
R.P.R. POSITIVE			
REVIEWS			

REPORTED BY _____

REMARKS

MONZE DISTRICT HOSPITAL
AIDS COMMUNITY AND HOME BASED CARE MONTHLY
RETURN FORM

NAME OF RURAL HEALTH CENTER:

MONTH:

NUMBER OF HIV/AIDS PATIENT IN A CATCHMENT AREA:

NUMBER OF HIV CASES DIAGNOSED AT R.H.C.:

NUMBER OF HIV PATIENTS PRE-COUNSELED AT R.H.C.

NUMBER OF HIV/AIDS PATIENTS POST-COUNSELED AT R.H.C.

NUMBER OF HIV PATIENTS VISITED AT HOME:

NUMBER OF HIV PATIENTS ADMITTED AT R.H.C.:

NUMBER OF HIV PATIENTS/AIDS DIED AT HOME:

NUMBER OF HIV/AIDS DIED AT R.H.C.:

NUMBER OF HIV/AIDS REFERRED IN:

NUMBER OF HIV CASES REFERRED OUT:

NUMBER OF HIV/AIDS CASES DROP IN:

HOW MANY CARDS ISSUES DURING THIS MONTH:

HOW MANY PATIENTS HAVE CALLED FOR A VISIT THIS MONTH:

WHAT WAS THE REASON FOR CALLING:

MEDICAL:

SOCIAL:

PSYCHOLOGICAL:

ANY OTHER REASON:

NO. OF ANTI-AIDS CLUBS FORMED:

LIST OF ACTIVITIES PERFORMED BY THE CLUBS:

TOTAL NO. OF ORPHANS IN THE AREA:

LIST OF COMMUNITY ACTIVITIES ORGANIZED:

1.

2.

3.

WERE SCHOOLS VISITED? YES: NO:

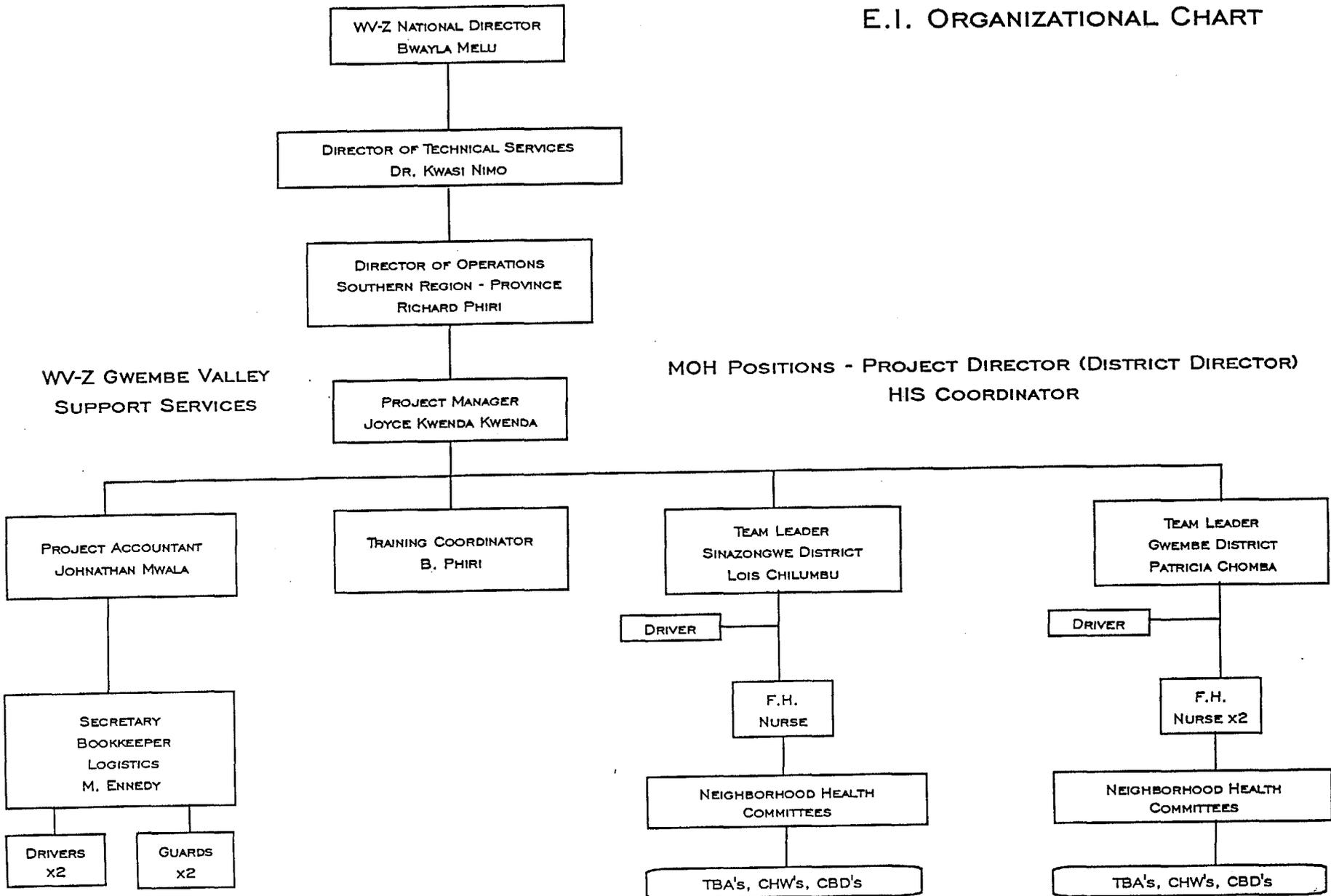
DO THEY PERFORM ACTIVITIES? YES: NO:

WHICH SCHOOLS:

GENERAL COMMENTS:

SIGNATURE: DATE:

E.I. ORGANIZATIONAL CHART



WV-Z GWEMBE VALLEY
SUPPORT SERVICES

MOH POSITIONS - PROJECT DIRECTOR (DISTRICT DIRECTOR)
HIS COORDINATOR

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**WORLD VISION INTERNATIONAL
CHILD SURVIVAL PROJECT**

JOB TITLE: Project Manager

QUALIFICATIONS: Form V with University degree/diploma in Public Health

EXPERIENCE: At least 5-10 years working experience in any Government/NGO related to health or women in development.

JOB DESCRIPTION:

1. Coordinate implementation of all project activities.
2. General responsibility for the liaison and coordination with Government, planning office and non-government specialists in Health and Water.
3. Manage and organize training seminars and workshops for project staff, trainers, trainers of trainers and for beneficiaries.
4. Manage all project funds and ensure proper accountability.
5. Supervise project staff and ensure that project activities are properly carried out.
6. Ensure technical quality of project interventions.
7. Provide on-the-job training for project staff.
8. Responsible for all project reporting back to World Vision Zambia.
9. Responsible for all project planning in respect to implementation plans.
10. Be responsible for links between the project and World Vision Zambia.
11. Maintain coordination with other partners and NGOs providing primary health care in Gwembe and Sinazongwe Districts and liaison with other relevant organizations in Zambia.

**WORLD VISION INTERNATIONAL
CHILD SURVIVAL PROJECT**

JOB TITLE: Training Coordinator

QUALIFICATIONS: Diploma in Health Education/Social Sciences

RESPONSIBLE TO: Project Manager

RESPONSIBILITIES:

- ▶ Coordinates and communicates with the Project Manager on issues concerning training activities.
- ▶ Ensures that all conditions are favorable and facilities available for undertaking training and all parties are informed of training activities
- ▶ Prepares training curriculum for community health workers, traditional birth attendants and other health professionals and acquires training materials, i.e. programs, films, slides.
- ▶ Arranges accommodation for all participants in appropriate location.
- ▶ Arranges (schedules) for clinical experience for CHWs, TBAs, etc.
- ▶ Participates in actual training session and facilitation.
- ▶ Acts in the absence of Project Manager.

**WORLD VISION INTERNATIONAL
CHILD SURVIVAL PROJECT**

JOB TITLE: Program Accountant

JOB PURPOSE: To control finances, provide financial guidance, record and maintain all financial related documentation in a manner that is professional and satisfies both World Vision Filed Financial Manual procedures and donors alike.

REPORTS TO: Program Manager

MAJOR RESPONSIBILITIES:

1. Reconciliations

Prepare reconciliations each month by the agreed date, having identified the correct account balance, and prepared JEs to bring the account to that balance on the following:

- 1.1 General bank reconciliation
- 1.2 All 180 debtor accounts
- 1.3 All 190 prepayment accounts
- 1.4 All 22, 210 creditor accounts
- 1.5 All 230 payroll accounts
- 1.6 240 flow-thru account

2. Maintain Assets Register

3. Payroll

- 3.1 Update and run payroll for each month
- 3.2 Run bank letters and assist in the preparation of checks to have all payroll payments each month.
- 3.3 Prepare payroll journal by the agreed time.
- 3.4 Prepare the tax year end reports for submission to Zambia Revenue Authority by the required date.

4. Reporting

- 4.1 Review progress against deadlines to ensure that team members are up-to-date on financial matters.
- 4.2 Provide informal guidance/direction to team members needing to understand financial issues.
- 4.3 Take responsibility to ensure that monthly and quarterly financial reports are produced accurately and on time.
- 4.4 Prepare a daily cash sheet, giving a true reflection of the program's position as of the previous day to the Program Manager by 10.00 hours every day.
- 4.5 Calculate the weighted average rate of exchange to be used on each month's report.
- 4.6 Prepare monthly and year-end accruals where necessary.
- 4.7 Prepare individual forms for Monthly Financial Report Accounts 300, 150, 180, 190, 200 and fixed assets by the agreed date.

5. Data Entry

- 5.1 Enter and correct as necessary CDVs into cashbook.
- 5.2 Posting JEs in the cash book.

6. Advances and Imprests

- 6.1 Review imprest reimbursement claims and expense reports, to ensure that they are supported by proper invoices and receipts for appropriate expenditure, and ensure that they are accurate. Sign off on those reports.
- 6.2 Reconcile the advance accounts monthly and carry out the account reconciliations on the ledger.
- 6.3 Ensure that absolute minimum amount is outstanding in advances at month-end, ensuring in particular that no travel or purchase advances are overdue.

SKILLS/ABILITIES REQUIRED

- 1. Integrity
- 2. Commitment to meeting deadlines
- 3. Team player
- 4. Accurate and good judgement
- 5. Computer expertise in the use of Lotus and computer-based accounting systems.

QUALIFICATIONS

- 1. Technical competence such as that of ZDA or equivalent academic qualification, either formal or obtained by experience.
- 2. Minimum 5 years experience in similar capacity.

**WORLD VISION INTERNATIONAL/ZAMBIA
CHILD SURVIVAL PROJECT**

JOB TITLE: Secretary

JOB PURPOSE: To ensure that the office runs smoothly and efficiently reflecting professionalism in all aspects of office management.

REPORTS TO: Program Manager

MAJOR RESPONSIBILITIES:

1. To manage the affairs of the office in a professional manner.
2. To plan with the Program Manager a on daily basis the work to be performed.
3. To ensure program documentation is well filed and easily retrievable.
4. To supervise all services for staff located at the office.
5. To manage all affairs of the Guest House, ensuring that it is kept to acceptable standards.
6. To organize all appointments for the Program Manager and control/screen persons coming to the office.
7. To produce and prepare program documentation to acceptable, well-presented professional standards, such as management reports, annual reports, etc.
8. To organize all monthly/staff meetings in consultation with the Program Manager.
9. To be well-versed in all areas of the program activities to be able to articulate correctly any aspect of the program to interested parties.
10. To perform other extra tasks that are related to the project as and when required.

PREFERRED SKILLS AND ABILITIES

1. Computer literate
2. Pleasant personality
3. Good interpersonal skills
4. Good writing skills

QUALIFICATIONS

1. Secretarial Qualification
2. 100-120 WPM/Shorthand 110 WPM
3. Minimum 3 years in similar position

R-5
B1

**WORLD VISION INTERNATIONAL/ZAMBIA
CHILD SURVIVAL PROJECT**

JOB TITLE: Driver

JOB PURPOSE: To ensure that program vehicle entrusted to project is maintained in a roadworthy condition and able to be used to undertake trips as required by the program.

REPORTS TO: Senior Nurse/Project Manager/Training Coordinator

MAJOR RESPONSIBILITIES:

1. To maintain the vehicle in a roadworthy condition.
2. To undertake regular routine maintenance services on the vehicle.
3. To undertake errands as and when required by the program.
4. To provide transportation services to the office staff.
5. To provide monthly status report of the vehicle.

PREFERRED SKILLS/ABILITIES

1. Good interpersonal skills
2. Mechanically competent
3. Good driving skills

QUALIFICATIONS

1. Form III School Certificate or equivalent in formal or informal training or experience.
2. Class I driving license.
3. Clean driving record.
4. No criminal record for the last five years.

**WORLD VISION INTERNATIONAL/ZAMBIA
CHILD SURVIVAL PROJECT**

JOB TITLE: Senior Nurse

JOB PURPOSE: To ensure that the child survival activities and supervision of community-based workers are carried out on a timely and professional basis.

REPORTS TO: Program Manager

MAJOR RESPONSIBILITIES

1. To draw up child survival field visitation trips for the outreach team.
2. To ensure the drug requirements of the outreach team are fully stocked and the cold chain maintained.
3. To supervise the Family Health Nurses to ensure quality work is being achieved.
4. To submit weekly and monthly reports for all activities for which you are responsible.
5. To ensure that all child survival activities are in conformity with Ministry of Health District Plans.
6. To attend to any meetings that are organized in the District by Government or other groups of a reputable nature.
7. To liaise/network with Ministry of Health to ensure that our participation in the District is being acknowledged and appreciated at the district, provincial and national levels.
8. To organize training of Traditional Birth Attendants (TBAs) and Community Health Workers (CHWs), and Community- Based Distributors (CBDs) as and when needed.
9. To ensure adequate supervision of community-based workers during outreach visits.

**WORLD VISION INTERNATIONAL/ZAMBIA
CHILD SURVIVAL PROJECT**

JOB TITLE: Family Health Nurse

REPORTS TO: Senior Nurse

JOB PURPOSE: Implementing and evaluation of child survival services at delivery point.

MAJOR RESPONSIBILITIES:

1. To prepare plan of activities with team leader.
2. To teach parents about target child survival messages and encourage them to utilize fully the existing PHC services.
3. To prevent diseases by placing emphasis on nutrition and immunization of children.
4. To diagnose and treat "killer" diseases of children wherever possible and refer cases if in doubt.
5. To immunize children.
6. Recognize and treat minor problems of pregnancy.
7. To motivate and counsel parents on child spacing and liaise with the PPZA/MOH representative in the District.
8. To recognize malnutrition and provide rehabilitation.
9. Assess the health needs of a community.
10. Evaluate the immunization coverage.
11. To supervise community-based workers (CHWs, CBDs, TBAs) during outreach visits.
12. To work straight shifts Monday to Friday of 08.00 to 16.45 hours and also beyond working hours.
13. To compile and submit child survival reports regularly.

**MINISTRY OF HEALTH
MONTHLY RETURN
FOR HEALTH CENTRES AND SUB-CENTRES**

Name of Unit..... Officer I/C.....
 Address/Box no..... Actual Beds Cots
 District..... Province..... Month..... Year
 POPULATION IN CATCHMENT AREA.....

NEW CASES THIS MONTH	O/P First Attendances		Total New Cases	I/P Admissions		Deaths	
	AGE:			<5	5+	<5	5+
	<5	5+					
Diarrhoeal Diseases							
Other gastro-intestinal							
Whooping Cough							
Measles							
Acute poliomyelitis							
Malaria							
Sleeping Sickness							
Tuberculosis (suspected)							
Syphilis							
Gonorrhoea							
Other STD							
Bilharzia							
Round worms							
Other worms							
Other communicable diseases							
Malnutrition							
Anaemia							
Eye Diseases							
Ear Diseases							
Dental diseases							
Upper respiratory infection							
Pneumonia							
Other pulmonary diseases							
Pelvic inflammatory diseases							
Other genito-urinary diseases							
Skin infections							
Skin Ulcers							
Fever-undiagnosed							
Injuries/poisoning							
All other diagnosed diseases							
Symptoms/ill-defined condition							
Maternity admissions							
TOTALS							

Reattendances for Outpatient Care need not be tallied.

TOTAL FIRST ATTENDANCES
 TOTAL ADMISSIONS
 TOTAL INPATIENT DAYS
 TOTAL DEATHS
 TOTAL REFERRED

ANTENATAL/POSTNATAL

	AnteN	PostN
1st Attendance		
Re-Attendance		
Total		

TETANUS TOXOID

1	
2	
3	
4	
5	

BIRTHS

Total deliveries
 Total live births
 Live births < 2.5kg
 Still births
 Neonatal deaths
 Abortions

FAMILY PLANNING CLINIC ATTENDANCES

New Acceptors	
Continuing Acceptors	
Total Attendances	

NOTE: New Acceptors refers to those who have never before adopted a method of family planning.

IMMUNIZATIONS (Static and mobile units)

AGE:	Under 1	Over 1
BCG		
Polio I		
Polio II		
Polio III		
DPT I		
DPT II		
DPT III		
Measles		
Protected child		
Booster - Polio		
Booster - BCG		
Booster - DPT		

NOTE: "Protected Child" refers to those children who have completed the full series of immunizations (excluding boosters) within the target dates. This is an important indicator which should be routinely reported.

UNDER 5 CLINICS (These figures should be abstracted from the Children's Clinic Monthly Return; field activities should be included.)

AGE:	0-11mo	12-23mo	24-59mo	Total
New Attendances				
Re-Attendances				
Weight below lower curve				

PRIMARY HEALTH CARE (Enter number of community health workers and traditional birth attendants for catchment area)

	CHW	TBA
Number of trained PHC workers		
Number of active/reporting this month		
Total deliveries assisted		

Completed by _____
 Signature

Date _____

Comments/problems

SUSTAINABILITY READINESS INDEX

Score 1 for Yes and 0 for No or Not Applicable. Most answers can be taken from preassessment forms.

Program

- | | | |
|-----------------|------------------------------------------------------------------------------------------------------------------------------------|-------|
| 1. | Program services are of a quality that users will pay for. | _____ |
| 2. | Most country programs/affiliates are focused on 1–2 services. | _____ |
| 3. | In a representative country program, services can be delivered efficiently to thousands. | _____ |
| 4. | The program approach does not transfer material goods or cash directly to beneficiaries, either on a household or community level. | _____ |
| 5. | Most participants make contributions (fees, labor, in-kind materials, voluntary services) to receive benefits. | _____ |
| 6. | User groups administer services and play a major role in reducing costs. | _____ |
| 7. | To access new and technical types of services, your organization partners with others. | _____ |
| 8. | There is a high degree of standardization among services provided to individual clients or groups. | _____ |
| 9. | Models, methods, and complimentary systems are replicated among country programs. | _____ |
| 10. | Cost-per-benefit comparisons have been made between your program(s) and other similar ones. | _____ |
| Subtotal | | _____ |

Cost-Recovery

- | | | |
|-----------------|-----------------------------------------------------------------------------|-------|
| 1. | Fees are charged to cover some or all of the main service costs. | _____ |
| 2. | The country program does not pay participants to attend training or events. | _____ |
| 3. | The country program recovers a significant part (more than 10%) of costs. | _____ |
| 4. | The country program calculates what percentage of local cost it recovers. | _____ |
| 5. | The country program downsizes or eliminates unfunded services. | _____ |
| Subtotal | | _____ |

Revenue Mechanism for Local Earning

- | | | |
|----|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|
| 1. | At a country program level, ideas exist about product(s) or service(s) that can charge fees to recover costs. | _____ |
| 2. | Country program staff have set a target for local earnings and are aware of the price to be charged and the volume of sales necessary to achieve this target. | _____ |
| 3. | Country program staff have methods to make users aware of the price, qualities, and way to access their goods or services. | _____ |
| 4. | Country program staff have recruited and educated a <i>clientele</i> population (as opposed to a “beneficiary” population) willing to pay fees. | _____ |
| 5. | Country program staff are organized to deliver and collect efficiently for a good or service. | _____ |

Subtotal

Financing Strategy

- 1. Grant funding constitutes 50 percent or less of cash funding of most country programs affiliated with your PVO.
- 2. Country programs are able to earn 20+ percent of costs locally.
- 3. Local monetary contributions cover a significant part (20 percent+) of country program costs.
- 4. Governing structures (boards) of country programs are active to raise funds.
- 5. Country program management and technical staff are skilled at earning or raising funds locally.

Subtotal

Management Systems

- 1. Country program accounting systems can segregate the costs of delivering each principal product/service.
- 2. Unit cost per benefit/beneficiary can be calculated for each main service.
- 3. Models to break-even financially by earning local revenues exist for at least one country program.
- 4. Country programs have financial information system to track actual versus projected revenues, expenses and cash flow.
- 5. At least one country program has a business plan with financial targets for local earnings.

Subtotal

Values

- 1. It is permissible for programs to charge user fees.
- 2. Most staff believe low-income users can afford to pay something for services.
- 3. Most staff believe too many handouts hinder rather than help development.
- 4. It is permissible, even preferable, for country programs to earn locally.
- 5. One can be nonprofit and still think and behave in a businesslike way.
- 6. It is acceptable to acquire and make assets perform financially.
- 7. It is acceptable to eliminate unfunded cost centers.
- 8. Country program governance structures are supportive of increased earning.
- 9. Country managers value programs on a scale that can reach many thousands and support efforts to specialize.
- 10. Good program impact and scale are highly valued and rewarded.

Subtotal

Management

1. Program supervisors have financial information which allows them to understand how results are related to expenses. _____
2. Country managers receive financial information on impact, expenses, and income, and use it to make program decisions. _____
3. Country management has a written strategy for sustainability. _____
4. HQ management has a written sustainability strategy for managing and providing assistance to the portfolio of country programs. _____
5. Management personnel with business experience are recruited in the organization. _____
6. Productivity indicators exist and are used to evaluate performance for field staff and supervisors. _____
7. At HQ level, criteria exist and are used to graduate programs from support. _____
8. Community members are involved in determining the kind of services to be charged for, the price, and improvements to service delivery. _____

Subtotal _____

SUSTAINABILITY READINESS INDEX SCORE

(Count "yes" marks only.)

Criteria	Score
Program(10)	
Cost-Recovery (5)	
Revenue Mechanism(5)	
Financing Strategy(5)	
Values(10)	
Management(8)	
Total(48)	

1. What are two or three implications for a desired future state for your organization?