

Antimicrobial Resistance
Country-Level Implementation Pilot in Zambia:
Rapid Appraisal of Advocacy Activities

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Links Media
Gaithersburg, MD

Assessment Team

Marisabel Sánchez, M.P.H.
Dolores Briones, M.S.S.W.

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ABBREVIATIONS AND ACRONYMS

AED	Academy for Educational Development
AIDS	Acquired immunodeficiency syndrome
AMR	Antimicrobial resistance
APUA	Alliance for the Prudent Use of Antibiotics
ARCH	Applied Research in Child Health
ARV	Antiretroviral
AWG	Advocacy Working Group
BU	Boston University
CAs	Cooperating agencies
CBoH	Central Board of Health
CDC	Centers for Disease Control and Prevention
CHAZ	Churches Health Association of Zambia
DHMB	District Health Management Board
DTCs	Drugs and Therapeutic Committees
ECZ	Environmental Council of Zambia
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GH	Bureau for Global Health [USAID]
GRZ	Government of the Republic of Zambia
HIV	Human immunodeficiency virus
HSSP	Health Systems and Services Project
ITG	Integrated Treatment Guideline
JICA	Japan International Cooperation Agency
KAP	Knowledge, Attitudes and Practices
LDHMB	Lusaka District Health Management Board
LUDHMT	Lusaka Urban District Health Management Team
MDR	Multi-drug resistance
MoH	Ministry of Health
MSH	Management Sciences for Health
NAC	National AIDS Council
NDP	National Drug Policy
NGO	Non-governmental organization
NMCC	National Malaria Control Centre
OTC	Over the counter
PMTCT	Preventing Mother-to-Child Transmission
PRA	Pharmaceutical Regulatory Authority
PRDU	Promoting Rational Drug Use
QA	Quality Assurance
RBM	Roll Back Malaria
RPM Plus Program	Rational Pharmaceutical Management Plus Program
SAIDI	South American Infectious Disease Initiative
SP	Sulfadoxine-pyrimethamine
SEAM	Strategies for Enhancing Access to Medicines
STG	Standard Treatment Guidelines
STI	Sexually transmitted infection

TB	Tuberculosis
TZ	<i>Times of Zambia</i>
UNZA	University of Zambia
USAID	United States Agency for International Development
USG	United States Government
UTH	University Teaching Hospital
WHO	World Health Organization
ZCA	Zambia Consumer Association
ZDM	<i>Zambia Daily Mail</i>
ZNBC	Zambia National Broadcasting Corporation

EXECUTIVE SUMMARY

Antimicrobial resistance (AMR) is promoted through the overuse, misuse, and under-use of antimicrobial drugs. As AMR develops, the effectiveness of treatment for infectious diseases decreases and mortality, morbidity and treatment costs increase—threatening both health and healthcare systems. The issue of AMR has become increasingly more urgent in the face of the continued emergence and spread of tuberculosis (TB), HIV/AIDS, malaria, influenza, and multi-drug-resistant bacterial infections. Governments and institutions do not possess the capacity to endlessly supply increasing amounts of resources to develop new drugs nor can society continue to be productive in the face of such threats.

In response to this urgent and critical health issue, the World Health Organization (WHO) completed and published a global strategy plan for containment of AMR in September 2001.¹ To ease the implementation of this comprehensive and complex strategy in developing countries, more succinct methodologies for development and implementation of systematic approaches emerged.² Consistent with these efforts, the United States Government (USG), through the U.S. Agency for International Development (USAID) and its Global Health Bureau (GH), funded multi-partner efforts to focus on the design and implementation of country-level containment strategies.³ Management Sciences for Health (MSH)/Rational Pharmaceutical Management Plus (RPM Plus), Academy for Educational Development (AED)/CHANGE, Alliance for the Prudent Use of Antibiotics (APUA), Boston University (BU)/Applied Research in Child Health (ARCH), and Harvard Drug Policy Group initiated the conceptual work for designing country-level AMR containment efforts in various countries.⁴ The actual implementation of the work was formally initiated in early 2004 by RPM Plus and AED/CHANGE in collaboration with APUA.

For several years, USAID/GH has been providing funding support for AMR activities to the RPM Plus Program to address infectious diseases and reduce the emergence and spread of AMR. With this funding, RPM Plus and its partners developed training materials for drug and therapeutic committees; indicators to assess antimicrobial use in hospitals; support of research initiatives that influence appropriate and effective behavioral changes to

¹ World Health Organization. (2001). *WHO global strategy for containment of antimicrobial resistance*. Geneva, Switzerland: Author.

² World Health Organization. (2002). *Implementation workshop on the WHO global strategy for containment of antimicrobial resistance*. Geneva, Switzerland: Author.

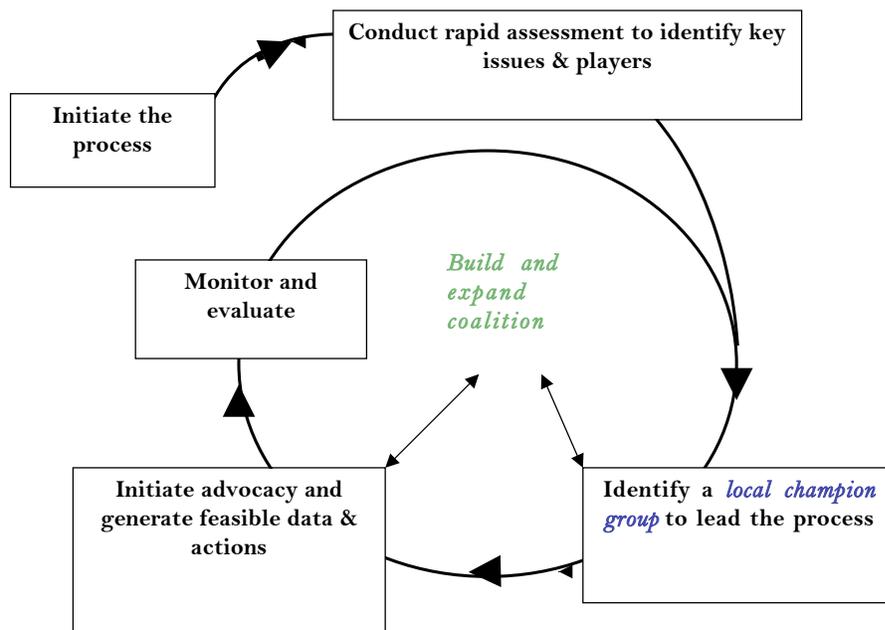
³ U.S. Agency for International Development. *Antimicrobial resistance (AMR): Overview*. Retrieved November 20, 2005, from http://www.usaid.gov/our_work/global_health/id/amr/

⁴ Rao, S., & Reyes, C. (Eds.). (2002, July). *Rational Pharmaceutical Management Plus Program: Activity and product status report, April–June 2002*. Published for the U.S. Agency for International Development by the Rational Pharmaceutical Management Plus Program. Arlington, VA: Management Sciences for Health.

improve antimicrobial use; and a rapid assessment tool for malaria programs. In addition, RPM Plus assessed the impact of provider reimbursement mechanisms and managed care on antimicrobial drug use.

In early 2004, with support from RPM Plus and AED/CHANGE, a group of experts in Zambia began to formulate a new framework for addressing AMR, which focused on applying advocacy and communication strategies to facilitate change at the individual, societal and public-policy levels. As illustrated in 2005 during a presentation at the 2005 Strategies for Enhancing Access to Medicines (SEAM) Program Conference in Ghana, the elements of the country-level AMR strategy involved:⁵

Elements of the Country-Level AMR Approach



A coalition was formed for the purpose of: 1) involving diverse sectors of Zambian civil society such as government agencies and institutions, international donors and programs, academia, professional associations, businesses, and the news media to address the issue of AMR; 2) attaining effective collaboration between sectors; and 3) raising awareness to achieve better results in the use of antimicrobials. A number of activities were implemented during a two-year period, including:

⁵ Joshi, M., Pollock, N., & Hazemba, O. (2005). *Supporting country-level strategies for advocacy and containment of antimicrobial resistance, SEAM conference, June 20–22, 2005.*

- Formation of the APUA-Zambia Chapter
- Establishment of an Advocacy Working Group (AWG)
- Capacity building for AWG members, stakeholders and journalists
- Mass communication

These activities achieved a degree of success as articulated by a Zambian journalist who stated, *"After attending [AWG activities] I realized how important [AMR] is. I personally grew interested in the issue. I paid attention and did a number of articles. The media has to make noise and help sensitize the people. Just like HIV/AIDS, this [AMR] is a life-and-death issue. If I am not infected, somehow I will be affected."* A significant level of excitement was generated in Zambia immediately following the implementation of the advocacy activities. High attendance at events was evidence of the significant level of interest and commitment generated in Zambia for implementing AMR containment strategies. However, current progress towards continuous implementation has slowed significantly. Aware that only action can produce change, funders, AWG members, journalists, and other stakeholders have begun to ponder the long-term viability of the advocacy strategy. As noted by one stakeholder, *"It is not only about [implementing] activities, but you also have to know how to sustain a level of effort that will bring about permanent change."* Another stakeholder noted, *"Action is required for sustainability. We need to see progress. We need to get re-energized and re-think where we are heading to and how to get the resources to do it."*

To provide insight into some of the factors that are contributing to the delay of the Zambian effort, as well as to document lessons learned and achievements, Links Media was commissioned by MSH/RPM Plus to conduct a rapid appraisal of the advocacy activities that have taken place in the past two years. The rapid appraisal consisted of in-person interviews conducted during a visit to Lusaka, Zambia in December 2005; telephone interviews with members of the AWG, stakeholders, and journalists; and a review of the literature in order to appraise the following:

- Most important achievements and lessons learned
- Sustainability factors
- Recommendations to overcome barriers

This report presents a number of general findings and broad recommendations to further advance advocacy efforts for the sustainability of AMR containment strategies in Zambia. The findings are segmented into seven broad categories, described as follows:

- Commitment
- Prestige, Name Recognition, Credibility and Constituency

- Organization, Structure and Capacity
- Strategic Action
- Framing and Positioning the Issue
- Funder Representation
- Working with the Media

Findings are presented in the form of a brief summary followed by a corresponding recommendation.

I. INTRODUCTION

A. AMR AND ZAMBIA

Zambia is one of the poorest countries in the world with HIV/AIDS, malaria, respiratory infections, diarrhea, and malnutrition being major causes of death. In 2004, 920,000 cases of HIV infection, 89,000 deaths, and 630,000 AIDS orphans were reported. It is estimated that 16.5 percent of the adult population in Zambia is infected with HIV. About 84 percent of these are between the ages of 20 and 29. Estimated lifetime mortality risk from HIV/AIDS suggests that for a Zambian population with an HIV prevalence of 16.5 percent, more than half of all youth now aged 15 will die of AIDS.⁶ Zambia is one of 15 focus countries of the U.S. President's Emergency Plan for AIDS Relief (the Emergency Plan). Under the Emergency Plan, Zambia received nearly \$81.8 million in FY2004 to support a comprehensive HIV/AIDS prevention, treatment, and care program. In FY2005, the United States committed an additional \$132.9 million to support Zambia's fight against HIV/AIDS.⁷ Malaria is endemic in the country, remaining the leading cause of morbidity and mortality, even amid coexisting epidemics of HIV/AIDS and TB. There are over 4.8 million cases of malaria, in a country of just over 11 million people.⁸

Zambia's first drug of choice to fight malaria used to be Chloroquine, but high levels of resistance (up to 64% in some areas) forced it to shift to Fansidar [the generic name for a sulfadoxine + pyrimethamine (SP) drug]. Unfortunately resistance to SP has also increased dramatically and in some areas has reached a level as high as 19%.⁹ Chloroquine resistance in Zambia is a distressing illustration of the consequences of AMR. Fortunately, malaria surveillance in sentinel sites resulted in a change in drug policy due to drug resistance. The Government of the Republic of Zambia (GRZ) and the Zambia Roll Back Malaria Partnership, in collaboration and with resource-support from various donors, adopted new tactics against malaria, including: (1) combining a new generation of antimalarial treatments like Coartem with large-scale prevention programs such as insecticide spraying and use of insecticide-treated bed nets; (2) mobilization of public-private partnerships between pharmaceutical companies such as Novartis and international organizations such as the WHO, Bill and Melinda Gates Foundation through PATH, and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); (3) capacity-building initiatives targeted at health professionals and

⁶ GlobalHealthReporting.org. *Recent news on Zambia from the Kaiser Daily HIV/AIDS Report*. Retrieved November 20, 2005 from

<http://www.globalhealthreporting.org/countries/zambia.asp>

⁷ UNAIDS. (2004). *Report of the global AIDS epidemic*.

⁸ The Global Fund. *Fact sheet: Zambia 2004*. Retrieved November 20, 2005, from http://www.theglobalfund.org/en/in_action/events/africamalariaday/2004/factsheet_zambia/

⁹ Ibid.

management, including industry-funded “Novartis Malaria Case Management Educational Program”; and (4) massive public education campaigns.¹⁰ Zambia became the first country in Africa to adopt Coartem as first-line therapy in national treatment guidelines. This measure was deemed controversial and was at first opposed by a number of major international donors due to the high cost of the treatment.¹¹

As noted by Dr. Naawa Sipilanyambe of Zambia’s Malaria Control Program in the Novartis Annual Report 2004, the issue is not only about supplying drugs, but efforts must be complementary to include capacity building in a number of areas to adequately address the problem and strengthen the system.¹² Professionals from the National Malaria Control Centre (NMCC) understand that “*[m]onitoring resistance is crucial. AMR determines the treatment policy of malaria in the country. AMR is probably the major guiding factor of treatment guidelines—that’s how crucial it is. We need collaboration, good coordination of the existing resources, and committed advocacy to properly address AMR in Zambia. We have to address public- and private-sector physicians. We are doing it right with both. For private physicians, we are now providing them with subsidized Coartem and educating them as well.*” As noted by a senior member of the National AIDS Council (NAC) in Zambia, “*Treatment starts before patients start treatment—with strong vigilance and high standards for treatment criteria, even for the newer drugs, ARVs [antiretrovirals] for HIV/AIDS. Compliance, monitoring response to treatment, training activities, and AMR must be part of a comprehensive program.*”

Whether dealing with malaria or any other infectious diseases, already overwhelmed health professionals in Zambia have witnessed the dreadful and distressing morbidity, mortality, and treatment costs associated with resistant infections over the years. The AMR problem in Zambia, as stated by a physician from University Teaching Hospital in Zambia (UTH), is complex and involves a huge number of factors such as costs, epidemics such as HIV/AIDS, the emergence of new disease-causing organisms, an inadequate surveillance system, lack of coordination and communication amongst health professionals and administrators, and consumer use. As this physician states, “*It is cheaper in the short run to prescribe without the scientific evidence on faith value, but in the long run is more expensive, and resistance is bound to develop. For chest infections that were not a big*

¹⁰ Roll Back Malaria. (2005). *Africa Malaria Day launch 25 April: United against Malaria*. Lusaka, Zambia: Ministry of Health, Health Communication Partnership (Zambia, WHO, USAID, and UNICEF); Zambia’s national malaria control program expands, intensifies with lift from new partners. (2005, November 14). Retrieved November 20, 2005, from <http://www.reliefweb.int/rw/RWB.NSF/db900SID/KKEE-6J5MSY?OpenDocument>

¹¹ Novartis. *Rolling Back Malaria: Zambia* (Novartis Annual Report). (2004). Retrieved November 20, 2005, from http://www.novartis.com/annual_reports/2004/malaria.shtml

¹² Ibid.

problem in the past admissions have gone up as much as 40 percent. Essentially when someone comes with chest infections, we start them up with the antibiotics that are available. I cannot take a risk on the patient. I go for the output—the patient getting better—first. As a practitioner, you don't look at resistance first. You help the patient first." Another physician added, *"We are the vehicles between the drug and the patient. 80 percent of our conditions daily are infections, and you prescribe not based on epidemiological surveys but on empirical therapy—we don't wait for cultures. We are not using new technologies to detect what germ causes disease."* Lack of research and poor information sharing among the laboratory, pharmacy, physician, and administration were also mentioned as major contributing factors to the problem. *"Administrators lack the knowledge to make adequate drug purchases based on the resistance patterns, because the data is not there, or when it is there, it comes in too late or not consistently enough. I walk the lab at least once a week to see if the pattern is changing. So when we teach residents, we give them the information. But the data-collection system needs improvement. We have to know the trends of diseases that are coming in a timely fashion. We [health providers] need linkages among ourselves and with administration. We need better communication."*

Global initiatives [e.g., GFATM, USG Presidential Preventing Mother-to-Child Transmission (PMTCT)] have increased the flow of drugs to countries in order to combat HIV/AIDS, malaria and TB. The need to manage the use of these drugs properly through raising awareness and interventions is highly crucial to AMR strategies. As noted by a member of the NAC in Zambia, *"Malaria, TB and HIV have given us more urgency to look at AMR. This issue starts with the prescribers. They have a responsibility to educate consumers about resistance. They [consumers] have to be clear that if they don't take their drugs, they won't get better. In our program, I want to make it easier for the patient to avoid resistance—pharmacovigilance, adherence, and drug quality are key to the resistance issue for our program in Zambia."*

"AMR in Zambia is an issue, and we are meeting the challenge," said a high-ranking official for the Central Board of Health (CBoH). *"We are currently working on the newly named Pharmaceutical Regulatory Authority (PRA). We need to strengthen our national surveillance system and ensure quality of post-marketing surveillance, work with the private sector, and focus on consumers as a priority. Very little has been done at this level [consumer level]."*

B. THE ZAMBIAN PILOT PROJECT

2003 ACTIVITIES

Initial Impression of the Situation on the Ground

In July 2003, a U.S.-based team representing RPM Plus, AED/CHANGE, and USAID/GH visited Zambia to explore the possibility of designing and implementing a country-level pilot program to contain AMR in the country.¹³ A number of activities took place during the visit, as described below:

- Discussions with Zambian representatives of RPM Plus and ARCH.
- Meetings with USAID/Zambia to present the proposed pilot activity and obtain feedback and recommendations.
- Meetings with local stakeholders and potential partners to learn about level of interest in AMR and ongoing AMR containment, monitoring, and awareness-raising activities. Conversations were held with representatives from the GRZ, CBoH, professional societies, other cooperating agencies (CAs) and partners.

A number of issues and recommendations emerged during the visit, as outlined below.

Selected Issues

- The AMR problem in Zambia had not been addressed systematically, with clearly identified priority activities. The country's approach had been to switch to an alternative drug when one drug no longer appeared to work.
- An influx of new drugs and more complex treatment regimens, entering the country via various donor programs, had demanded greater awareness of and attention to potential resistance.
- The GRZ, donors, and technical agencies had a myriad of competing public-health priorities.
- There was a tension between addressing the immediate needs of current patients versus those of future patients. In Zambia, prudent use does not always mean less use, and the task of holding new antimicrobials in reserve when the need for them is urgent was potentially difficult.
- There was a lot of interest in and concern about AMR among country stakeholders. Several key individuals expressed interest in being part of a champion group. The Director General of the CBoH expressed strong interest in the proposed activity. The proposed pilot was viewed as a mechanism for people working across the different disease programs to

¹³ Joshi, M., Pollock, N., and Sommer, M. (2003). *Exploratory visit for the antimicrobial resistance country-level implementation pilot in Zambia, July 6–18, 2003: Trip report*. Submitted to the U.S. Agency for International Development by the Rational Pharmaceutical Management Plus Program. Arlington, VA: Management Sciences for Health.

see the common ground in what they were seeking to accomplish and to collaborate.

- APUA-Zambia chapter was undergoing development.
- A good foundation of resistance-related investments and activities was in existence on which a more systematic AMR plan could be built, to include:
 - Development of Standard Treatment Guidelines (STGs), Essential Drugs List, and National Formulary
 - Courses on Promoting Rational Drug Use (PRDU)
 - Anti-Malaria Drug Management
 - Technical Review of Antimicrobial Drug Information
 - Drug and Therapeutics Committee Workshop
- AMR initiatives had included:
 - Existence of National Drug Policy (NDP)
 - Quality Assurance (QA) Program with Infection Control as a component
 - Drug and Therapeutics Committees in each district
 - The U.S. Centers for Disease Control and Prevention (CDC) supporting Zambia's TB laboratory surveillance and providing technical assistance to strengthen STI and TB surveillance, Japan International Cooperation Agency (JICA) supporting virology laboratory
 - Initiative towards starting Pharmacovigilance Program with AMR as a component
 - Ongoing effort to pass a new "Pharmacy and Medicines Bill" and plans to have a strengthened drug regulatory body to be renamed as the "Pharmaceutical Regulatory Authority" (PRA)
 - Change in malaria treatment policy (from chloroquine to artemether/lumefantrine) had been implemented with "correct use" and "compliance" as important components
- A foundation of policy, research, monitoring and surveillance, regulatory, management and advocacy activities existed. The activities were supported by the GRZ, USAID/Zambia, CDC, WHO, and JICA, and could generate support and formulate AMR strategies.
- WHO regional office support for AMR surveillance of epidemic diseases (cholera, dysentery, meningitis, dengue, and plague) is done as part of its Integrated Disease Surveillance program.

- In general, there was limited AMR data. Where available, data was not being adequately communicated to clinicians, policymakers, or STG committees and was not being used for decision-making.
- Lack of evidence-based information had made it difficult to prioritize the level of attention devoted to specific resistance issues.
- Drug availability in the public sector had improved, but remained a problem in some areas. Unrestricted availability in the private sector was alarming program managers and practitioners in both the public and private sector.
- There was already concern regarding the use of ARVs and possible loss of their effectiveness due to resistance. ARVs, including those from drug wholesalers, were available in the private sector. Stigma in seeking treatment from appropriate sources was identified as a major issue.
- Misperceptions regarding the appropriate use of SP existed among consumers and health workers.
- Implementation of the new malaria policy was expected to generate valuable lessons for future changes in drug policy regarding drug distribution, health-worker training, and consumer education.
- Drugs and Therapeutic Committees (DTCs) had been established in public hospitals. Unfortunately, manpower constraints had affected their ability to function in the provincial hospital and the mission hospital that were visited. The Lusaka District Health Management Board (LDHMB) was supporting activities to improve DTCs.
- The Drug Regulatory Authority had limited capacity. Over-the-counter (OTC) availability of antimicrobials, along with suspected poor drug quality, were issues of concern.
- Very little research on AMR and interventions to contain it had been carried out.
- Sharing of information was limited, in part due to a lack of formal mechanisms to disseminate and use the information collected.
- Competing priorities were viewed as a challenge, but the proposed approach was perceived as an opportunity.

Selected Recommendations

- Need for broad responses involving a wide range of stakeholders who understand the magnitude of the problem and the level of commitment required from them.
- Critical need for participation of donors who supply drugs via various global initiatives in the effort to ensure that the drugs remain effective. The need for monitoring drug use was recognized, but nothing had been implemented. Drug quality was not being monitored, but there was an expectation that this activity would be supported through some of the GFATM grants.
- Need to engage the most important stakeholders such as:
 - The GRZ, donors, technical agencies, Lusaka Urban District Health Management Team (LUDHMT), CDC—important player in managing Global Fund HIV/AIDS monies—and the private sector
- Need to have discussions with JICA—supporting the Virology Laboratory at UTH—regarding QA of existing laboratories and/or drug quality.
- Need to demonstrate cost-saving measures that would result from efforts to slow the pace of resistance.
- Need for the proposed pilot to be managed locally and supported by the CBoH.
- Need for more research, and information dissemination.

A noteworthy comment in the 2003 trip report states that there was interest and a potential for the District Health Management Boards (DHMBs) to carry out and fund the AMR pilot activity once it had reached the point of prioritizing interventions with local stakeholders and donors.

2004 ACTIVITIES

Initiating the Process

In March 2004, another visit from a U.S. team followed to plan and facilitate, along with local partners, the first meeting of AMR stakeholders. In addition, during the visit the team worked with selected partners to adapt tools, gather data, and delineate the process for advocacy activities. During the visit local stakeholders conveyed a number of new issues and recommendations, as described below.

Selected Issues

- As the Emergency Plan activities moved forward in Zambia, there was concern and need for human capacity building and resistance-prevention initiatives. There was concern regarding the distribution of large volumes of drugs for HIV/AIDS expected to arrive in the country.
- Following news reports, there was increased concern about the possibility of some drug-resistant HIV strains in one of the provinces. The USAID mission was concerned with the potential for widespread resistance and hoped that the proposed AMR activity would help to move forward the advocacy and activity in Zambia to ensure appropriate use of the drugs.

Selected Recommendations

- Advocacy to create heightened awareness about the dangers of AMR was needed for the country. The proposed AMR containment effort was viewed as a value-added activity to the Emergency Plan.

With specific regard to the planning process for the proposed AMR containment activity, the following issues were raised:

- Need for local leadership engagement in planning and championing the activity.
- Importance of positioning AMR as an across-the-board issue affecting all stakeholders.
- Need for documentation of the Zambian launch so that it would be a valuable and easy-to-follow guide for other countries to adapt.

Interviews previously conducted in February and March 2004 with stakeholders concluded that most people recognized the problem of AMR, and agreed that there was a need for urgent action and that it was more costly not to do anything. The existing level of activities and interventions was deemed inadequate. Lack of properly organized and analyzed data made it difficult to address the problem effectively.

Stakeholders' Meeting

During the March visit a meeting was held with stakeholders to share views on Zambian AMR issues, to begin building a coalition, and to propose and gain consensus on the process in Zambia. Some key issues raised during the stakeholders' meeting are outlined below.

Selected Issues

- Irregular availability of essential drugs in the public sector
- Drug quality issues
- Poor prescribing and dispensing practices
- Non-compliance on the part of patients
- Unrestricted OTC availability of antibiotics
- Unlicensed drug vendors
- Illegal inflow of drugs from bordering countries
- Lack of diagnostic facilities
- Lack of trained health workers

Other issues raised by other individuals included:

- Need to keep high-level officials informed and engaged
- Need to consider both urban and rural set-ups while planning activities
- Need to keep CDC informed

The group also identified a number of interventions underway, including: Integrated Treatment Guideline (ITG) for frontline health workers in Zambia; implementation of new malaria policy; and a Churches Health Association of Zambia (CHAZ) drug-supply management training.

Formation of Advocacy Working Group (AWG)

A multidisciplinary working group of "*champions*" was formed to spearhead mainstream support for the issue of AMR as an integral part of all health programs in Zambia.¹⁴ The group became known as the Advocacy Working Group (AWG), endorsed by the CBoH. The AWG comprised members from the public and private sectors, the CBoH, UTH Bacteriology and Virology Laboratories, NMCC, professional societies, and cooperating partners. Consistent with WHO global strategies for AMR containment, the Zambian group prioritized a number of strategies on advocacy.

A number of key elements of the proposed country AMR containment process were identified, including:

- Situation analysis and data gathering
- Identification and engagement of key players or stakeholders
- Implementation of a workshop for stakeholders to identify and prioritize interventions
- Monitoring and evaluation of the implemented interventions

¹⁴ Joshi, M., Zimicki, S., & Sommer, M. (2004). *Initiation of antimicrobial resistance country-level implementation pilot in Zambia, March 2–13, 2004: Trip report*. Submitted to the U.S. Agency for International Development by the Rational Pharmaceutical Management Plus Program. Arlington, VA: Management Sciences for Health.

A draft scope of work for the local AMR Working Group was created, which included the following activities:

- Moving the AMR advocacy process forward over the next four to six months (March to August 2004)
- Attending a series of meetings and/or workshops (about one day per month) at crucial decision-making points in the process
- Reviewing and providing comments on tools, collected information, and data analysis as needed
- Participating in the meetings/workshops to be conducted during the process
- Participating in the Consensus Workshop
- Reviewing outcomes of the Consensus Workshop

Additionally, the following components were reviewed and discussed:

- Data collection tools, including pharmaceutical assessment tools
- Draft action guide and its possible reorganization
- Hiring of consultant(s) for data gathering and analysis
- Budget requirements
- Timeline of activities (4-6 months)

At the time it was suggested that the Zambia APUA chapter take on the champion role, but the larger group of stakeholders opted for broader-based representation. A tentative list of the AMR AWG members was proposed and included: Professor Chifumbe Chintu, Dr. D.V.C. Mtonga, Ms. Ernst Mwape, Mr. Oliver Hazemba, Mr. Caesar Mudondo, Dr. James Mwansa, Dr. J.C.K. Chisanga, Dr. Naawa Sipilanyambe, Ms. Mubiana Macwan'gi, and Ms. Ann Zulu.

Rapid Appraisal

The AWG in collaboration with the CBoH, USAID, AED/CHANGE, MSH's RPM Plus Program and other stakeholders conducted a rapid appraisal of the AMR problem in Zambia (drug-resistance situation analysis). A summary of the findings of the appraisal can be found in the August 2004 trip report.¹⁵ Pivotal country information of use for decision-making at various levels contained in the summary report includes:

- AMR levels and trends
- Malaria treatment failures 1995-2002
- Surveillance capacity:

¹⁵ Joshi, M., Pollock, N., & Miralles, M. (2004). Antimicrobial resistance country-level implementation pilot in Zambia: Trip report of a follow-up visit in August 2004. Submitted to the U.S. Agency for International Development by the Rational Pharmaceutical Management Plus Program. Arlington, VA: Management Sciences for Health.

- Reference laboratories: AMR surveillance
 - Microbiology Laboratories: diagnostic testing and use of reference laboratories
 - Guidelines
 - Laboratory QA
 - Funding sources
 - Role of the private sector in AMR activities
 - Use of data
 - Training
 - Information needs and information dissemination
 - Data management
- o Pharmaceutical management:
 - Treatment seeking/drug use
 - Prescribing
 - Drug supply
 - o Policy and legal framework
 - o Treatment guidelines
 - o Essential drug list
 - o Education, training and capacity building
 - o Quality

Media Presence and Communication Channels

A survey on the media presence and communication channels in Zambia was also conducted as part of the rapid appraisal activity. This activity focused on identifying appropriate communication channels for information dissemination, understanding the role of the media in delivering health information in Zambia, and determining the information needs of the media in order to disseminate information. The survey covered the *National Mirror*, *The Post*, *Times of Zambia (TZ)*, *The Farmer Magazine*, *Zambia Daily Mail (ZDM)* and Zambia Broadcasting Corporation (ZNBC). The major findings topic areas included (1) coverage of health stories, (2) type of health topics covered, (3) sources of health stories, (4) constraints encountered in getting health stories, (5) public's access to health information, (6) journalists' general awareness on health topics, and (7) training of journalists. A number of recommendations were provided in the report, including:

- o Increase access to reliable information.
- o Build relationships with media reporters.
- o Contribute consistently to health columns.
- o Provide user-friendly context.
- o Provide logistical assistance to journalists covering drug-related issues.

- Sponsor training with background information and key concepts about drug resistance.
- Facilitate journalists' access to health information and sources.
- Enhance professional support by cooperating with the formation of a media health-watch group.

Additionally, other specific recommendations were made including that stakeholders consider using the term "drug resistance" instead of "antimicrobial resistance."

AWG Retreat

In August 2004, a Retreat was organized by the AWG to identify steps to further move country-level pilot implementation activities forward. A number of tools were developed in order to facilitate discussions held during the retreat, including guidance sheets on AMR trends, AMR surveillance, pharmaceutical management, and drug-use behavior and communications.

Some issues discussed during the retreat included:

- Rationale, sources of data collection, and findings of the rapid appraisal, which included prescribing and dispensing practices, treatment-seeking behavior of the public, drug quality, surveillance, and collection/management of information.
- Rationale for the "Call for Action" document of what the AWG understands is the real and potential threat of AMR in Zambia, and development of a workplan for what needs to be done about it.

To support the development of the "Call for Action," a number of recommendations were made, including:

- Hiring a consultant to oversee planning for proposed stakeholder meeting activities, including the preparation of press releases.
- Collection of materials and identification of local stakeholders who could be involved in their adaptation.
- Strengthening the AWG's capacity to move the advocacy process forward through team building and leadership development activities.
- Supporting the AWG in developing a coherent advocacy strategy to help ensure a successful stakeholder meeting and sustain momentum after stakeholder meeting.

- Using the lessons learned from the Zambia experience to revise the approach for application in a second country in 2005.
- Suggesting (based on limited representation at the retreat) that the AWG members assign alternates to attend meetings when they cannot. This will maintain the group's broad representation and also have the added benefit of engaging a wider group of persons in these activities.

Immediately after the retreat and during a visit to the USAID Mission, a discussion followed about how best to sensitize donors to support AMR country-level activities. It was recommended that the CBoH coordinate donor meetings, given that monies went through CBoH. In order to ensure that AMR activities were supported with donor funds, it was suggested that the government put AMR activities in their action plan.

AWG Strategic Focus Workshop

In October 2004, the AWG met for two days to delineate advocacy strategies. During the meeting the AWG made a number of decisions regarding the development of an operational plan to enable them to fulfill the mission and goals of the pilot activity. It was also agreed upon that given the nature of the team, the actions and deadlines proposed needed to be reasonable and feasible. The action plan should focus on the performance of the team, but only when the action plan work activities were fully implemented.

Participants identified strategic elements of the plan as detailed below.

Mission Statement

To mainstream AMR as an integral part of all health information in Zambia

Target Activities

- Data collection on AMR*
- Establish a database on AMR*
- Training of trainers*
- Educate stakeholders*
- Continue with advocacy
- Disseminate data on AMR through various channels
- Raise media awareness of the problem of AMR
- Enhance GRZ awareness of the problem of AMR
- Facilitate adoption of AMR as an integral part of the training of health professionals

* Eliminated after further discussion.

Target Audience

- Decision makers such as politicians, ministers, educators, directors, donors (health directors), professional medical associates, media officials and editors, pharmaceutical companies (directors), pharmacy regulatory board, health officers (large companies), and heads of health institutions

Measures of Success

- GRZ changes policy in relation to AMR
- Wider availability of appropriate microbial drugs
- Wider dissemination of STGs
- Incorporation of AMR into health promotion programs
- Increased publicizing of AMR in the media
- Increased prominence of AMR in the curricula of institutions
- Establishment of a database on AMR
- Incorporation of AMR into Knowledge, Attitudes and Practices (KAP) and rational use studies.
- Pharmacy board listing ineffective treatment

- Pharmaceutical companies required to comply with new policies
- Each health institution having an effective therapeutic committee

Materials

- Call for Action (PowerPoint)
- Brochure
- PowerPoint presentation
- Fact Card
- Cholera Paper
- Malaria Policy Statement

Message – Strategic Approach

Large companies	Factual/social responsibility benefit
Donors	Encouragement
Professional associations	Factual
Media	Factual/solvable/warning
Institutes	Factual
Pharmaceutical companies	Factual/social responsibility benefit/market incentive (longer product life)
GRZ	Consequences
NGOs	Consequences
Regulatory boards	Consequences

Potential Messengers

- Media (columnists as well as factual articles)
- First Zambian President Dr. Kenneth Kaunda
- Former Ruling Party (UNIP) Secretary General (Grey Zulu)
- Big Brother Winner 2003, Ms. Cherise Makubale
- Voice of America representative, Mr. Kellys Kaunda
- Professional Associations – Secretariat
- Dr. Velepi Mtonga
- USAID Communications Unit
- Cartoonist (as part of information campaign)
- AWG members

Strengths

- Diversity: understanding
- Credibility
- Team members
- Professional expertise
- People are concerned (committed)
- Professional training
- Volunteers
- Support team

Weaknesses

- AWG's lack of time
- Day jobs
- Inconsistency
- Volunteers
- Lack of commitments
- Limited resources

Opportunities

- Possibility of success
- Reduction of AMR problem
- External support (the environment is conducive)
- Access to information
- Facilitation of implementation of WHO guidelines

Threats

- Other special-interest groups
- Pharmaceutical companies
- No control over stakeholders
- Limited government money
- Lack of current government support for AMR
- Cultural barriers (resistance to change/family influence)
- Lack of knowledge in external bodies (media) to make sure the message is loud and clear

AMR Stakeholders' "Call for Action" Meeting

AMR requires multiple interventions directed towards education, regulation, surveillance, and research. It also requires involvement of all stakeholders.
– From "Call for Action" meeting PowerPoint presentation

In November 2004, the AMR Stakeholders' "Call for Action for Preserving the Effectiveness of Drugs" meeting was held in Lusaka, Zambia, for the purpose of raising awareness about the problem of drug resistance, advocating for stakeholder participation in addressing the problem, and facilitating opportunities for ongoing discussions and action.¹⁶ The meeting attracted 70 participants representing diverse sectors from Zambia. High-ranking government officials and the news media were among the participants. Details from the meeting such as agenda, PowerPoint presentations, and news media coverage can be found in the November 12, 2004 trip report.

¹⁶ Joshi, M., Pollock, N., & Garrison, K. (2004). *Antimicrobial resistance stakeholders' "Call for Action" meeting: Lusaka, November 12, 2004*. Submitted to the U.S. Agency for International Development by the Rational Pharmaceutical Management Plus Program. Arlington, VA: Management Sciences for Health.

The Honorable Minister for Health in Zambia Dr. Brian Chituwo officially inaugurated the meeting. Group work, reporting, and plenary discussion followed a series of presentations. Professor Chintu, Chairman of the AWG, presented the “Call for Action” document to the audience. The document draws attention to all those concerned with the health of Zambians to come together and address the problem of failing effectiveness of drugs.

Standard Treatment Guideline

The official launch of the Standard Treatment Guideline (STG) also occurred during the “Call for Action” meeting. It was Dr. D.V.C. Mtonga, Director of Clinical Care and Diagnostic Services at the CBoH, who launched the STG on behalf of Dr. Ben U. Chirwa, Director General of the CBoH. The STG document covered all diseases common in Zambia. It also included the Essential Medicines List and Essential Laboratory Supplies List for the country.

In addition to the above activities, a generic draft “Workbook for Building Local Support for Containing Drug Resistance” was initiated to help the local stakeholders move the advocacy process forward. The workbook has been designed for periodic revision based on on-going lessons learned from the Zambian pilot.

A number of important follow-up activities, needs, and recommendations identified by meeting participants were:

- Identification and implementation of follow-up activities to maintain momentum.
- Support for AWG decision to expand AWG Secretariat membership and support for consultants to implement activities.
- Securing support from meeting participants to help provide technical and funding assistance to support the planning, coordination, implementation and resource mobilization for the three identified activities (pre-service training, use of media to increase awareness, and communication support to the Drug Regulatory Authority).
- Continuous support of AWG on media-related activities.
- Transportation expense support to members for attending the meetings, in order to increase attendance at AWG meetings.
- Continuous revision of the “Workbook for Building Local Support for Containing Drug Resistance.”

- Involvement of the Zambia Country Chapter of APUA. Collaboration with APUA Headquarters in Boston to help identify the local chapter's possible role and technical-assistance opportunities.

Development of APUA-Zambia Chapter and Work Plan

In early 2004, representatives from APUA traveled to Lusaka, Zambia to implement the official launch of an APUA-Zambia chapter. The event held at the UTH attracted more than 150 individuals, among them high-level government officials and members of the news media, such as Ellen Hambuba from ZNBC TV and Austin Kaluba from *TZ*. The visit also provided a forum for a brainstorming session to develop the chapter's 2004 work plan, which included some advocacy activities. It also offered an opportunity to get media coverage from ZNBC, which conducted an interview that aired in January. The focus was on the need to raise the awareness of health workers and the public on proper use of medicines, as well as the need to revise pharmaceutical law in Zambia.

During APUA's visit, the visiting team, accompanied by MSH-Zambia staff, also visited a number of key influential stakeholders and decision makers such as the former CBoH Director General Dr. Ben U. Chirwa. According to APUA's January 11-17, 2004 trip report, the response of those visited was very positive. Dr. Chirwa in particular stressed how important the purpose of the visit was for Zambia. In fact, he officially launched the chapter and talked about AMR issues in Zambia and the interest and commitment of the government to give it priority in the public health agenda. He also expressed concern about the urgency for addressing AMR issues as a priority for the GRZ within the context of HIV/AIDS, malaria, and TB. Similar sentiments were expressed by Dr. Dyness Kasungami and Dr. Abdirahman Mohammed (USAID Zambia Mission staff members), Dr. Stella Anyangwe (WHO representative in Zambia who also was the keynote speaker for the event), Dr. Eddie Limbambala (Medical Officer, Disease Prevention and Control), and Dr. T.K. Lambert (Board of Management Director, UTH), who additionally offered assistance for chapter activities.

The creation of the local chapter offered a greater opportunity for local professionals in Zambia to (1) establish linkages with APUA's network of staff, clinical and scientific advisory board members, international membership, and global network of chapters; (2) bring access to technical expertise in the areas of antibiotic use and resistance; and (3) obtain support in the coordination of the chapter's development and dissemination of tools and approaches, such as:

- Structuring South-South capacity building
- Coordinating field training and research
- Advocating improved policies for antibiotic use as well as education of consumers and providers

Drawing on its chapter development experience, APUA identified and developed a local chapter in Zambia to establish and promote the linkages

necessary to advocate for and achieve AMR policy change and to become a local resource for expertise and information on antibiotic resistance based on an understanding of and tailored to the local context and practices. APUA's strategy was to encourage the Zambia chapter to plan, organize, and carry out local research and educational initiatives to curb antibiotic resistance. In return, APUA sought to collaborate in the development of a model country process to promote evidence-based advocacy and action for AMR through clinical practice and policy improvement carried out by Zambian stakeholders. This process was presumed to (1) provide a framework of interventions to slow the emergence of resistance and to reduce the spread of resistant microorganisms in order to reduce the impact of resistance on health and health care costs and (2) benefit existing USAID programs—such as case management of acute respiratory infections, diarrheal disease, malaria, and sexually transmitted infections (STIs)—that rely on treatment with effective and affordable antimicrobial drugs.

During the initial stages of the chapter development, the APUA took the following steps:

- Worked with local clinicians and scientists in the selection of key individuals that met the criteria of champion groups and were instrumental in providing vital knowledge about AMR to enable more effective interventions to prevent and contain AMR
- Provided technical assistance to a local champion group to plan AMR interventions in Zambia within the context of the WHO Global Strategy for Containment of AMR
- Assisted local champion group in the assessment of AMR trends and intervention capacity and infrastructure
- Provided technical assistance to research studies to learn baseline information on AMR
- Gained commitment from Zambian stakeholders to compile action plans, research findings and products for future dissemination

The initial APUA Zambia Chapter included the following members:

- Mweemba Muvwimi – Chest Diseases Laboratory, UTH
- Chileshe Lukwesa Musyani – Pathology and Microbiology Department, UTH
- Betty Munalula – Physiological Sciences Department, School of Medicine, Lusaka
- Darlington M. Mwenya – Pathology and Microbiology Department, UTH
- Dr. James C. L. Mwansa – Pathology and Microbiology Department, UTH
- Dr. Lungwani T. Muungo – Pharmacy Department, School of Medicine, University of Zambia (UNZA)
- Mr. Oliver Hazemba – MSH Office, Lusaka
- Dr. Zulu Wamemba, UTH

A number of findings and recommendations were identified during the 2004 visit and subsequent trip report, as described below.¹⁷

Selected Findings

- Interviewed individuals were very enthusiastic about the creation of the chapter in Zambia.
- There was not a government-funded antimicrobial surveillance program in Zambia. However, the UTH acted as a reference laboratory. There was no network of laboratories.
- There was some interest from government authorities to further investigate and support AMR interventions, with emphasis on HIV, malaria, TB, ARI and diarrheal diseases.
- Local data on surveillance of AMR was available for some pathogens. However, this information suffered from technical flaws due to lack of appropriate technical protocols and QA.
- There were no acceptable QA protocols in place at the UTH microbiology laboratory.
- Zambia was receiving support from the Global Fund on Malaria, TB, and HIV/AIDS in the amount of \$74,945,056. Total disbursed to date was \$8,941,408.
- In 2004 the USG was committed to providing \$66 million to Zambia to help the country fight its HIV/AIDS epidemic.
- There were no other private AMR surveillance networks in Zambia.
- Following the Technical Workshop on AMR and Rational Drug Use conducted in April 2002, sponsored by MSH RPM-Plus in collaboration with APUA, it appeared that the LUDHMT had organized a number of relevant activities. In 2004, there was little coordination with the newly established APUA chapter and little information about the LUDHMT activities.

Selected Recommendations

- With APUA-International support, the APUA-Zambia chapter members are qualified and able to be engaged in recruiting individuals and organizations to work together on AMR, particularly in the leading regional infectious disease killers.
- As in other APUA chapters, a support person for the chapter coordinator should be hired to collect and tabulate data and prepare reports as required by the group. He/she also will take minutes and document sessions as well as manage logistical issues, such as scheduling meetings, informing potential participants and reminding them to attend.

¹⁷Sosa, A., & Stelling, J. *APUA-Zambia chapter development, January 13–17, 2004: Trip report*. Submitted to the Rational Pharmaceutical Management Plus Program, Management Sciences for Health, by the Alliance for the Prudent Use of Antibiotics, Boston.

- APUA International should continue to provide technical support and materials on AMR to guide the local chapter in developing an assessment tool that can serve as a model when developing chapters in other countries within the region.
- Expand chapter membership to include members/staff of the Ministry of Health (MoH), universities, professional associations, NGOs, and others.
- Community education and health care working groups should initiate focus groups on antimicrobial use and resistance in the community and obtain the feedback of residents.
- An advocacy group should be created to ascertain the skills needed to try to influence policy and decision makers.
- Chapter leaders should learn more about the status of LUDHMT plans and activities and consider the feasibility of coordinating activities where beneficial.

2005 ACTIVITIES

Message, Advocacy and Communication Workshops

In 2005, the AWG in collaboration with AED/CHANGE organized and facilitated a series of workshops to develop advocacy strategies and communication materials about drug resistance.¹⁸ During Workshop 1 (Workshop to Develop Advocacy Strategies and Communication Creative Briefs to Reduce Drug Resistance), six advocacy strategies and seven creative briefs were developed. During Workshop 2 (Workshop to Develop Draft Print Materials and Radio Spots to Reduce Drug Resistance), four of the creative briefs were developed into six communication materials:

- 2 draft radio materials for the consumer
- 2 draft print materials (brochure and poster) for the prescriber
- 1 draft radio spot script for the prescriber
- 1 draft print material for the provider (wall chart)

¹⁸ Soisson, D., & Shafritz, L. *Zambia trip report: Message, advocacy and communication workshops, Lusaka, February 23–March 4, 2005*. Washington, D.C.: Academy for Educational Development.

Sample Advocacy Strategies Developed

Advocacy component	
Issue	AMR is not included in many current programs due in part to insufficient funding
Goal/Objective	AMR reduction activities to be included in all programs, 1-Raise awareness of program managers on the importance of including AMR in their programs, 2-Ensure all include AMR-reduction activities in their plans, 3-Encourage programs to solicit funding for AMR
Target Audience	1-P/S Directors, 2-Program managers, 3-NGOs, 4- PHOs, DHBs, 5-Hospital Boards, 6-DEC
Message(s)	1-AMR is a serious problem that should be monitored and adequately funded. The cost of patient care will go down. 2-Program managers include AMR in your programs to increase the cure rate for patients and reduce the disease burden, 3-NGOs such as CHAZ to include drug-resistance reduction activities in their plans and adhere to standard guidelines on donations FBO, NGOs, To receive and donate drugs that meet the national standards to reduce drug resistance, 4-PHOs DHOs Hbs To include drug-resistance reduction activities in their plans to reduce the number of hospital visits, increase cure rate and improve the image of the institution and that health providers
Channels of Communication	P/S, Directors' meetings, Information package, presentations. Newspaper articles and NEWS Program managers Meetings, Information packages and presentations NGOs Meetings, Information packages, presentations, NEWS features, radio, video documentaries
Building Support: Who Can Help You?	The media, professional bodies, WHO, NGOs
Work Plan Steps	1-Letter to PS, 2-Meetings with PS and Directors and present information package, 3-Meeting/presentations with program manager, 4-Meeting/presentation with CBoH and PHOs, 5-Media articles
Monitoring and Evaluation	1-Reports on the number of managers made aware, 2-Ensure that NGOs receive and donate drugs that meet the required standards, 3-Spot checks and exit interviews on implementation of programs. Evaluation: 1-Review district plan to document how many include AMR-reduction activities in their plans, 2-Conduct operational research to determine how much funding has been allocated for AMR.

Sample Creative Briefs Developed

Identifying the Key Components of Advocacy #4	
Issue	Inadequate diagnostic capacity in health system: 1. Not all diagnostic labs are fully functional (at least 20 level 1 facilities are not equipped to do culture and susceptibility tests). 2. Staff is often insufficient. 3. Existing staff has no training in conducting drug-resistance testing. 4. Will need quantity of supply to keep pace with increasing volume.
Goal/Objective	Advocacy component
Target Audience	Ministry of Finance and Economic Development, MoH – planning unit, donors, parliamentary health committees, neighborhood health committees, DHMBs, financial committees of health facilities, Environmental Council of Zambia (ECZ)
Message(s)	General: Your decision to support increased funding for high-quality laboratory services will improve the health and productivity of our country/neighborhood/district/catchment area.
	General: An investment of X in improving lab services will save Y Kwacha on health costs in our country/neighborhood/district/catchment area by saving money on drugs by improving appropriate prescription.
	ECZ: With your help we can improve the health and productivity of Zambian citizens by reducing their exposure to the dangers of infectious wastes.
Channels of Communication	Media proposals/presentation of data, meetings, rally/drama plus discussion – for communities/neighborhood health committees, letters for health facilities and DHMBs
Building Support: Who Can Help You?	AWG, APUA, Pharmaceutical Society of Zambia, CBoH – Directorate of Clinical Care and Diagnostic Services, Media, NMCC, NAC, TTB, IMCI, ART, CBoH/MoH local MPs/community leaders, religious and traditional leaders
Work Plan Steps	1. Short description of problem and suggested solutions. 2. Meet with potential partners to review and modify description, get their support, and commitment to responsibilities. 3. Write the proposal including data and budget information and timeline (2-3 pages). 4. Submit it to the targets and request meeting. 5. Meeting – to present, discuss. 6. Modify and repeat steps 4 and 5 until adopted. 7. Draft a letter for PS–MoH to sign and send. 8. Copy and send letters to DHMB, health facilities, media, partners. 9. Publicity. 10. Organize drama/rallies (DHMB).
Monitoring and Evaluation Monitor Monthly:	Review the work plan steps to determine progress on each

During the workshops, a number of key issues were identified along with recommendations:

- The AWG should develop a name and a logo for their group that indicates its objective. Name and logo should be incorporated in all materials.
- The AWG should seek funding to support production and dissemination of draft print materials and radio spots produced during the workshops.

The latter activity was coordinated by the AWG in 2005 in the form of a meeting targeted to the donor community. The purpose was to solicit funding commitment for the dissemination of print materials and radio spots. However, for a plethora of reasons, donors did not attend.

Workshop for Physicians

In June 2005, a workshop for physicians on implementation of STGs for infectious diseases of major public health importance was organized in Lusaka.¹⁹ This activity was part of the AWG plan to conduct pre-service and in-service training activities for health care professionals to advance the AMR advocacy and containment process. The implementation and utilization of the STGs were discussed, and a number of recommendations also were provided. A total of 31 Zambian participants, representing the public and private sectors, attended the workshop, 15 from Lusaka and 16 from outside Lusaka.

¹⁹ Joshi, M. (2005). *Workshop on implementation of standard treatment guidelines to support antimicrobial resistance (AMR) containment in Zambia: June 27–29, 2005*. Submitted to the U.S. Agency for International Development by the Rational Pharmaceutical Management Plus Program. Arlington, VA: Management Sciences for Health.

II. THE RAPID ASSESSMENT

In December 2005, Links Media conducted a rapid assessment of the Zambian advocacy activities in order to gain insight into the lessons learned and identify opportunities for future activities.

A. THE METHODOLOGY

The appraisal was contracted for an effective start date of December 8, 2005 and an estimated completion date of January 30, 2006. Ms. Sanchez and Ms. Briones conducted the appraisal using qualitative, in-depth interviews and literature reviews. The interview schedule covered a three-week period and included travel to Lusaka, Zambia by two team members to conduct in-depth personal interviews over a one-week period. Additional interviews were completed by telephone. More than 20 interviews provide the information for this report. Interviews averaged one to three hours in length. The team prioritized a list of interviewees based on input from RPM Plus/MSH staff. The in-person interviews were conducted with AWG members, stakeholders (APUA members, government officials, business people, academics, donors, and health professionals), and journalists. The 13 high-priority informants were generally individuals with linkages to major programs having great relevance to AMR activities. The nine medium-priority informants were those with linkages to secondary programs having great relevance to AMR activities. The eight low-priority informants were those with linkages to programs having some relevance to AMR activities.

High-priority interviewees were identified as individuals most likely to contribute information about AMR activities with respect to history, lessons learned, impact, and insights for the future. The Lusaka visit was conducted from December 11 to 18, 2005. Unfortunately, some high-priority informants were not available for the entire period of the rapid assessment due to the restricted schedule, competing seasonal festivities, and other time commitments. The limited flexibility in the schedule did not allow for leveraging the "snowball" method of identifying additional key individuals for targeted interviews while in country. This referral strategy is invaluable as it adds depth and breadth of perspective to the interviewing process by leveraging contacts and connections that otherwise would not be obvious, available, or accessible. This action also provides an insight into the influence of stakeholders and gatekeepers.

While in Lusaka, the team also reviewed literature, such as newspapers, articles, and government materials having some relevance to the issue of AMR.

The qualitative, in-depth interviews were organized and modified based on the identity and role of the interviewee. The main questions and associated probes are outlined below.

Key questions:

- Most important achievements, shortcomings, and lessons learned
- Recommendations to sustain or exceed achievements
- Recommendations to overcome shortcomings
- Recommendations to anticipate and/or prevent shortcomings

Other probes:

- What is the strategic vision of the overall Zambia AMR project? How do the advocacy work plan objectives and activities contribute to this vision? How have they adversely impacted this vision?
- How effective has AWG been in moving from planning to implementation? Please identify specific examples of collaboration.
- To what degree have advocacy activities influenced other programs within Zambia to integrate AMR into their programs/initiatives (TB, malaria, etc.)? Please identify specific examples.
- To what extent has the technical assistance supported field training and coordination for advocacy? What other technical assistance would have contributed to the success of the initiative? What elements of the technical assistance currently are being used or are planned for upcoming activities?
- Using a scale from 1-5 (1 = least progress/5 = highest progress), how would you rank implementation of the work plan? What would push implementation forward? What would maintain the momentum?
- What has slowed or held back implementation of the work plan?
- How would you rank interest and commitment by AWG and others to continue with advocacy activities? What individuals and partners are essential in the process of keeping the plan alive?
- What advocacy activities are you currently involved in? How is your organization planning to contribute to advocacy activities?
- As your organization's representative on the coalition, are you authorized to commit your organization to the goals of the initiative?
- What specific assistance might be helpful to improve or strengthen the cohesion and coordination of the group and its activities?
- What specific activities, resources, and commitments do you need in order to fully support AMR advocacy activities? How can the AWG assist your program? What specific activities, resources and commitments are you able to provide?
- How can the AWG assist your program and how you can assist the AWG in preventing/combating drug resistance in Zambia?

- Is there some area we haven't asked you about that you would like to comment about? Do you have any other comments? Are you able to elaborate further on any of your input?

For journalists:

- Do you primarily cover health issues? How long have you been covering health issues? How about AMR? Probe for malaria, TB, and HIV.
- What are your main sources for health leads? Probe for malaria, TB, HIV, and AMR. State institutions, research institutes, NGOs, specialized articles, VOA, and others (please specify). How frequently are these issues covered by your form of media (in your judgment)? Probe for daily basis, once a week, less than once a week.
- What type of story is covered most frequently? Probe for reports, analysis, commentary, investigation, or other. Probe for which one would most likely cover a story related to AMR.
- Which health issue is covered most often? Probe for malaria, TB, HIV, and AMR.
- Probe for their perspective on the Call for Action activity and AMR in Zambia. Probe for areas of key interest, and linkages to other issues such as drug quality, other infectious diseases, etc.
- Do the media in Zambia cover the health situation in other countries of the region? Probe for malaria, TB, HIV, and AMR. What sources of such information can you name?
- What kind of training, information sharing or source access (other than press conferences) would you prefer (by themes; journalist approaches and techniques; working with sources; promotion; relations with NGO and institutions; etc.)? Probe for courses, workshops, materials, online reporting sources, etc., in which they would like to participate.

III. FINDINGS AND RECOMMENDATIONS

Commitment

Findings:

One of the most remarkable strengths of the AWG as well of the APUA-Zambia chapter and other stakeholders is the collective passion and commitment they share for promoting AMR containment strategies in Zambia. This commitment is expressed professionally—through long hours devoted to volunteer and pro-bono work—as well as regular attendance at meetings and events miles away at their own expense for the purpose of finding creative ways to implement advocacy activities and ensure that AMR containment strategies are implemented in the country. As one AWG member said, “We currently do not have money for the [radio PSA] project we had planned to implement. But somehow we will find a way to continue the work no matter what.” This determination is a noteworthy pledge.

A significant number of individuals involved in AMR advocacy activities tend to be the same core group that are involved in other public health advocacy groups in Zambia. For example, some members of AWG are core group members of APUA-Zambia. They also participate in malaria, TB, HIV/AIDS initiatives, and activities related to the PRA. These responsibilities and roles present both opportunities and challenges. One opportunity is that members are able to communicate informally and mobilize stakeholders quickly. A major challenge is that members are often overextended and not always available. In addition, they are not properly acknowledged for the work that they have done.

These individuals function in the AWG not only as advocates but also as facilitators, coordinators, and administrative support since the group no longer has an operating budget that provides for staffing. In 2004, the AWG had funding for staff and was able to implement advocacy activities more efficiently. Today, they lack pivotal administrative support and technical assistance to coordinate meetings (develop agendas, record minutes, etc.) and to provide other support including troubleshooting, leadership, and advocacy training. This role has been informally shared amongst members, with Mr. Oliver Hazemba as the primary coordinator. This lack of administrative and technical support creates undue burden on one person and is not conducive to sustained efficiency. Furthermore, the AWG does not have a permanent meeting space to conduct regular meetings. They rely on RPM Plus/MSH-Zambia for meeting space when it is available and lack funding for developing and disseminating needed materials. In addition, the AWG no longer has funding for advocacy and technical assistance.

Though AWG members are extremely committed, competing demands on their time and lack of adequate resources make the group feel overtaxed and fatigued, often resulting in member attrition and/or inactivity. This situation makes it difficult for the group to be proactive and progressive, and instead members find themselves reacting.

Outside the AWG, a number of stakeholders have expressed disappointment for the lack of continuity and updates regarding AMR advocacy activities. The “Call for Action” meeting not only energized stakeholders but also created expectations that have not been met. Many have been left wondering what happened to the group’s frequent activities, what the next steps are, and how they can still participate. They want to see progress and want to know what their role will be in the plan.

Recommendations:

AWG, APUA-Zambia, and other stakeholders should be recognized locally and internationally for their contributions to advocating AMR containment strategies in Zambia. Their actions, such as the distribution of the STGs, the “Call for Action” meeting, their collaboration with the news media, and their significant contributions to the development of the Pharmaceutical Regulatory Board (PRB), have brought the issue of AMR to the public agenda. Venues for recognition should be created, such as (1) achievement awards; (2) advocacy-innovation action grants; (3) national advocacy campaign management conferences; (4) a published report on their achievements; (5) opportunities to share their experiences in Zambia and abroad (e.g., South American Infectious Disease Initiative [SAIDI] meetings); and (6) local and international news media coverage.

In regards to staffing and other levels of support, the AWG should make it a priority to identify commitments for these resources. Funding is not the only manner in which the AWG can attain resources. Commitment for donated resources from stakeholders and allies can fulfill this need as well. In the long run, this strategic approach will contribute to sustainability.

To leverage membership resources, a strategic inventory of stakeholders should be conducted. Knowing each stakeholder and his/her specific role is essential for effective outreach, as this will allow for the group to leverage membership expertise, determine potential roles in the group, and reduce overlap in roles and responsibilities. Once the inventory is completed, an outreach plan should be developed with concrete steps for securing commitment and assigning participation. Not every stakeholder along the continuum has to be present at all times. Each can participate in different ways and at different times, such as participation in ad-hoc committees or campaigns.

Developing a master operational plan that includes the inventory of stakeholders and the outreach plan would provide a clear sense of exactly what will be asked of each member. When members know their roles, they will maximize their time devoted to group activities and be more efficient overall.

Analyzing the inventory of stakeholders also will allow the group to recruit new work group members who can strengthen capacity. With increased membership resources, a rotation system of duties should be put into place to lessen the demand of time and resources on the existing core group, while infusing it with new member capacity.

Prestige, Name Recognition, Credibility and Constituency

Findings:

Members of the AWG, APUA-Zambia and a significant number of AMR stakeholders are experts who possess superior academic credentials and are well known and recognized both in Zambia and abroad for work in their respective fields. Some AWG members have published and presented their work at national and international conferences. By and large they are senior-level professionals in their respective organizations and serve as officers on important boards. There are long-established professional and personal relationships among these individuals. Many individuals interviewed spoke of each other with great admiration and had respect for each other's work. They also have collaborated on a myriad of important local public health initiatives and have multiple, strong and diverse linkages with one another. The degree of credibility within the professional circles relevant to AMR is very high, particularly for a large number of AWG and APUA-Zambia members. Name recognition and credibility of AWG, APUA-Zambia and other key AMR stakeholders also was indicated by certain members of the news media, consumer associations, and private-sector businesses.

Furthermore, AWG, APUA-Zambia members, and other key stakeholders well represent various sectors of society in Zambia including government, academia, private health, public health, NGO, and private consulting. The composition of the AWG is appropriate and well constituted. Their connection, access, and reach to these sectors are fitting. However, the team is not complete, as representation of consumers and political representation in their work groups appears to be limited and informal.

Recommendations:

The AWG should leverage the prestige and credibility of its AWG members in order to promote the group and attract formal consumer and political representation as part of their overall stakeholder recruitment strategy.

Groups such as the Zambia Consumer Association (ZCA), which not only has the moral authority to speak on behalf of consumers but also has a record of effectiveness and experience in reaching down and out to its consumer base, should be enlisted in the AMR effort. The ZCA currently participates in a number of important national initiatives including a vitamin A use promotion and drug quality as part of the PRB. In terms of political representation, the AWG also should recruit or engage a political champion, an elected official or aspiring political leader who has the influence and credibility to advocate institutionalization of AMR containment strategies. Integrating these constituency groups into the AWG will be an important addition.

Organization, Structure and Capacity

Findings:

The AWG is currently organized as a coalition of members providing high-level expertise, coordination of activities, and moral support. Within the current organization and structure, the AWG has achieved significant success including the development and distribution of the STGs, obtaining news media coverage, providing stakeholder training, and hosting a well-publicized “Call for Action” meeting. Some AWG, APUA-Zambia, and other AMR stakeholders have been actively involved in the development of the newly created PRB and the development of the strategic plan.

AWG and other stakeholders interested in supporting advocacy of AMR containment strategies have expressed their desire for technical assistance for (1) improving their advocacy knowledge; (2) extending understanding of AMR and facilitating consumers’ education; (3) fostering the development of leaders; (4) working with the news media; and (5) keeping the issue on the public agenda to build consensus for action. Having this technical assistance will increase the AWG’s technical capacity to function at a higher level. Currently, training opportunities are limited.

Recommendations:

Regarding organizational structure, a number of opportunities are available to the AWG at the moment. It may strategize to influence the PRB to view and institutionalize AMR containment strategies as an integral part of the function of the PRB by creating an AMR division. Creating such a division could ensure that AMR does not become lost in the big picture. The AWG and other AMR stakeholders should leverage their political power, expertise, and influence and take advantage of the current climate to influence the PRB, at its inception, by launching a strategic advocacy campaign focusing on institutionalization of AMR.

If AMR is not institutionalized in the immediate future, the AWG should consider forming a collaborative. A collaborative has greater structure and therefore increased utility over time. It is an implementing body with more decision-making authority. It has more grounding effect, which can help in the long run for the institutionalization of AMR containment. Another entity may be able to organize the collaborative and provide administrative and technical support, or a staff person could function in this capacity. In this case, the advocacy efforts will need to be sustained through training. Without greater advocacy skills, the AWG will continue to be strained in articulating the urgency of AMR and the need for containment strategies.

Advocacy training should be achieved to ensure that the AWG has the technical knowledge to conduct advocacy campaigns effectively. Hands-on training can help to collaboratively design, implement, and monitor effective advocacy campaigns to further the strategy for containment of AMR. Investments should be made in performance-based advocacy training for a minimum period of two years that centers around: (1) advocacy campaign management; (2) building relationships with the government; (3) working with the media; (4) creating and maintaining coalitions; (5) developing and maintaining repositories of information; (6) development of practical tools and materials for advocates; and (7) advocacy through lobbying. Advocacy training also should focus on:

- Enhancing the collaborative capacity to run effective AMR advocacy campaigns
- Developing strategic advocacy campaign plans for partners' organizations
- Increasing the collaborative knowledge and skills in broad-based community mobilization in order to work more effectively with local-level associations in advocacy activities
- Transferring the technical skills learned in training programs into ongoing HIV, malaria, and TB advocacy campaigns
- Providing advocacy training programs to the collaborative partners at the provincial level
- Learning innovative new techniques for organizing and mounting effective advocacy campaigns from other counterparts

Strategic Action

Findings:

A number of important activities and actions with relevance to AMR are taking place in Zambia. Informally and formally, the AWG, APUA-Zambia, and other AMR stakeholders are playing a strategic role. Some are described as follows:

- The NAC recently appointed Dr. Ben Chirwa, a committed advocate of AMR containment strategies, as Executive Director.
- ACT No. 14 of 2004 established the PRA and defined its functions: to provide for the registration and regulation of pharmacies; to provide for the registration and regulation of medicines intended for human and animal use; to provide for the regulation and control of medicines, herbal medicines and allied substances; to provide for the regulation and control of the manufacture, importation, exportation, possession, storage, distribution, supply, promotion, sale and use of medicines, herbal medicines, and allied substances; to repeal the Pharmacy and Poisons Act of 1940 and the Therapeutic Substance Act of 1968; and to provide for matters connected with or incidental to the foregoing.
- A proposal was submitted to create a national surveillance system with adequate reference lab and sentinel sites.
- Zambia and South Africa recently have joined efforts to construct a modern research laboratory for HIV/AIDS and TB treatment.
- Zambia and the World Bank signed a US \$20 million loan agreement for malaria treatment.
- The Ministry of Education recently incorporated health treatment practices into their school curriculum.
- The Coartem-Malaria Treatment campaign is in full operation.

A strategic plan with broad objectives was developed, but no operational plan is in place. Furthermore, no strategic inventory of specific resources available in Zambia and abroad through APUA International (e.g., exchange research programs) is accessible.

AWG, APUA-Zambia, and other AMR stakeholders expressed some frustration about why they have not moved forward. Other AMR stakeholders also indicated disappointment with the lack of communication and follow-up after the “Call for Action” meeting and subsequent capacity-building events. They indicated great interest in supporting AMR advocacy activities but felt disconnected. The lack of knowledge about the resources currently available and accessible is partly responsible for the current situation. The AWG is reacting rather than being proactive. These frustrations are a natural stage in the development of advocacy efforts, and the group seems aware and willing to address them.

Recommendations:

The strategic plan should be revised. An operational plan with well-defined objectives should be created. The AWG also should capitalize on the work it has done thus far and move beyond the launch of the STG and the “Call for Action” event into the implementation and institutionalization phase.

A strategic inventory of resources available versus those needed should be discussed and developed. These resources need to be fully utilized. Instead of focusing on what resources are not available, AWG should exhaust those resources that are available, once an inventory is in place. For example, they could leverage their wealth of experts and provide stories to local and international journalists immediately. This unique capacity has not been exhausted. The AWG should develop alternative strategies to move forward and re-energize.

The AWG should become more formally engaged in the latest developments and activities and determine an action plan. Such a plan may include endorsement, moral support, mobilization, request for resource commitments, or lobbying. Additionally, the AWG should communicate with stakeholders and provide an update on AMR issues without any delay. Otherwise they may risk losing willing, interested, and supportive allies.

Framing and Positioning the Issue

Findings:

AMR is overwhelming. According to some interviewees, many in the private sector such as physicians and pharmacists may not know, understand or care about the AMR issue and its implications because their businesses have not yet been impacted. However, this could change if new laws regulating the private sector enter into effect and impact their business operations and profits. As stated by a pharmaceutical distributor, *“Then they [private-sector physicians, pharmacies, and drug distributors] will feel a greater sense of urgency to get involved in the issue.”*

Recommendations:

AMR should cover various aspects in order to become relevant to more actors including those in the private sector, such as physicians, pharmacies, and pharmaceutical distributors. AWG should identify and empower champions (e.g., key consumers and politicians) with reach into these sectors.

The AMR issue should be framed in the right context and timing. For example, due to the malaria treatment changes in Zambia, there is currently higher awareness about resistance to drugs on the part of consumers and the media. Furthermore, there is movement and evidence that also for HIV/AIDS, the general public is beginning to respond to community-mobilization efforts for individuals to know their HIV/AIDS status.

Issue-specific advocacy campaign plans should be developed in order to address specific areas such as drug quality, adherence, strengthening of the surveillance system, and risk of inappropriate use. This strategy will help

make the issue easier to understand, more manageable for the news media, and more focused for politicians.

Funder Representation

Findings:

The AWG organized an event targeted at funders. The purpose of the activity was to raise funds needed for the distribution of a series of radio announcements produced in collaboration with a group of Zambian newscasters. The event was well promoted, but funders did not attend.

Recommendations:

The AWG should recruit a funder representative to serve on the group or collaborative to educate members on how best to market fundraising events.

Working with the Media

Findings:

The journalists interviewed have a keen understanding and sophisticated knowledge of the issue. They have participated in previous AWG-sponsored workshops and also have attended training related to coverage of other health issues. They understand the issue perfectly and realize its urgency. They are aware of and willing to play their key role in sensitizing people. "[AMR] is a life-and-death situation. Similar to HIV/AIDS, if you are not infected, you are impacted." Such expressions are in part a result of the workshop but also come from personal experience with misuse of antimicrobials.

Although journalists are open and willing to step forward and play their critical role, lack of follow-up communication with AWG has caused disappointment. Even so, they remain extremely committed and ready to take an active part in communicating the issues of AMR to the public. They requested greater access to experts and manifested interest in making connections for international stories and media outlets.

Recommendations:

Sustaining relationships with the news media should be a major objective of the strategic plan. Keeping journalists informed and connected to the issue through periodical story ideas, news briefs, updates about the issue, and conversation, should be part of the operational plan. The media should be provided with material constantly and consistently. Increase access to reliable information.

Nurturing these relationships on a continuous basis and leveraging journalists' interest and desire to contribute also should be a priority.

ANNEXES

Statement of Work

ACTIVITIES

The scope of work under this assignment includes the following activities:

- A. Develop an appraisal strategy based on background information provided by RPM Plus. The activity will result in a plan to carry out the following tasks:

- Review of relevant documents and reports.
- In-person and telephonic interviews of the main implementing partners – RPM Plus/MSH and CHANGE Project/AED.
- Telephonic interview on the activities of the collaborating partner APUA.
- Discussion with and interview of Oliver Hazemba, the resident RPM Plus representative in Zambia.
- Discussions with and interviews of Zambian stakeholders.
 - AMR advocacy working group (AWG) members
 - Government officials
 - Key players attending the November 12, 2004 AMR Stakeholder Meeting held in Lusaka
 - Any other relevant stakeholders (representing professional associations and councils, training institutes, service sectors, consumer associations, NGOs, industry, etc.) in case not covered through interviews of those who attended the November 2004 Meeting

Ms. Marisabel Sánchez, MPH, Senior Assessment Specialist, and Dolores Briones, Assessment Specialist, will be responsible for the successful completion of this activity. The estimated time for preparing a draft strategy activity is five workdays. Within two more days the feedback from RPM Plus should be incorporated to produce a final strategy. The review of relevant documents will be subsequently completed within three workdays.

- B. Conduct a field visit to Lusaka, Zambia for discussion and interview with in-country stakeholders:
- AMR advocacy working group (AWG) members
 - Government officials
 - Key players attending the November 12, 2004 AMR Stakeholder Meeting held in Lusaka

- Any other relevant stakeholders (representing professional associations and councils, training institutes, service sectors, consumer associations, NGOs, industry, etc.) in case not covered through interviews of those who attended the November 2004 Meeting

Ms. Sánchez and Ms. Briones will be responsible for the successful completion of this activity. The estimated time for this activity is thirteen workdays, including travel time. The assessment team will start working in Lusaka on November 28, 2005.

- C. Develop a draft report detailing the background, methodology, findings, and recommendations for review by RPM Plus. The recommendations will include:

1. How to attain performance enhancement for continuation of the approach in Zambia
2. How to best initiate the approach in a second country
3. Revisions of the workbook reflecting lessons learned from the experiences obtained so far in Zambia.

Ms. Sánchez, Ms. Briones, Ms. Moore, Editor, and a Writer/Fact-Checking Specialist to be determined will be responsible for the successful completion of this activity. The estimated time for this activity is six workdays.

- D. Finalize the report based on feedback, if any, from RPM Plus

Ms. Sánchez, Ms. Briones, Ms. Moore, Editor, and a Writer/Fact-Checking Specialist to be determined will be responsible for the successful completion of this activity within two workdays.

- E. Provide a debriefing to RPM Plus
- Report on the results of the field visit and present key findings.
 - Provide a PowerPoint presentation summarizing the key findings.

Ms. Sánchez, Ms. Briones, and a Graphic/Media Specialist to be determined will be responsible for the successful completion of this activity within two workdays.

TECHNICAL DIRECTION

Performance of the work herein shall be subject to the technical direction of Dr. Mohan Joshi. As used herein, "Technical Directions" are

directions to the Contractor which amplify project descriptions, inputs, activities and objectives, suggest project directions, or otherwise inform and complete the general scope of the work. "Technical Directions" must be within the terms of this subcontract, and shall not change or modify in any way.

PLACE OF PERFORMANCE

Lusaka, Zambia; Arlington, Virginia, and Gaithersburg, Maryland, USA

DELIVERABLES

The Contractor must submit as results of performance progress under this contract, the following deliverables to be accepted in writing and approved by the Project Manager or his designee by the completion dates noted:

Deliverable Number	Deliverables	Completion Date	Performance Indicator
1.	Electronic copies of draft versions of (a) list of persons to be interviewed, (b) interview schedules, (c) interview guidelines and questions	November 13 th 2005	Draft versions of the list of persons interviewed, interview guidelines and schedules submitted to RPM plus
2.	Electronic copy of finalized version of # 1 deliverable based on RPM Plus feedback	November 30 th 2005	Finalized version of #1 submitted to RPM Plus
3.	Electronic copy of the detailed draft report of the appraisal (including background, methodology, findings/results, discussion, recommendations, annexes) for review by RPM Plus	January 8 th 2006	Detailed draft report submitted to RPM Plus
4.	Electronic copy of detailed raw data of each individual interview. Electronic copy of raw data will be provided in the way of handwritten notes from interviews and when available typed notes. Raw data is not defined as transcripts from interviews.	January 8 th 2006	Copies of raw data delivered to RPM Plus
5.	Electronic and hard copies of the final detailed report of the appraisal (including background, methodology, findings/results, discussion, recommendations, annexes, and any additional sections) based on feedback by RPM Plus on deliverable # 3.	January 15 th 2006	Detailed final report delivered to RPM Plus
6.	PowerPoint slide set used during debriefing of key RPM Plus staff	January 16 th 2006	Debriefing and PowerPoint slides provided to RPM Plus

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Individuals Consulted

1. Agness Chomba, UTH, APUA member
2. Anne Zulu, Medical Stores Limited
3. Anthony Mukwita, Media Institute of Southern Africa (MISA/Zambia)
4. Arnold Tutu, Choice FM
5. Ben Chirwa, NAC
6. Bernice Mwale, Pharmacy and Poisons Board
7. Bjorn Hofsten, Ngansa Pharmaceuticals
8. Caesar Mudondo, Unicare Pharmaceuticals Lusaka
9. Chipupu Kandeke, CHAZ
10. Cynde Robinson, Society for Family Health
11. Deborah Kaluba, Zambia Information Services
12. Dyness Kasungami, USAID Zambia
13. J.C.L. Mwansa, UTH, APUA member
14. Jabbin L. Mulwanda, JHPIEGO
15. Joseph Nikisi, JHPIEGO
16. Linda Mabumba, UTH, APUA member
17. Mabvuto Kango, NMCC
18. Mubiana Macwan'gi, Health Systems and Services Project (HSSP)
19. Mulenga Kasoma, Provincial Health Directorate
20. Myunda Ililonga, Zambia Consumer Association
21. Nanthalile Mugala, HSSP
22. Patrick Mwanza, Consultant
23. R. Mudondo, Unicare Pharmaceuticals Ltd
24. Ray Handema, UNZA – UTH
25. Sansan Myint, WHO
26. Soko Nyirenda, UTH
27. Velepi Mtonga, CBoH
28. Violet Kabwe, HSSP
29. Yassa Pierre, UTH, APUA member

Exploratory Questions



ANTIMICROBIAL RESISTANCE COUNTRY-LEVEL CONTAINMENT INFORMATION, ADVOCACY RAPID APPRAISAL SITE VISIT – INTERVIEW QUESTIONS

KEY QUESTIONS

- Most important achievements and lessons learned
- Sustainability factors
- Recommendations to overcome barriers

Other probes:

- What is the strategic vision of the overall Zambia AMR project? How do the advocacy work plan objectives and activities contribute to this vision? How have they adversely impacted this vision?
- How effective has AWG been in moving from planning to implementation? Please identify specific examples of collaboration.
- To what degree have advocacy activities influenced or are they influencing other programs within Zambia to integrate AMR into their programs/initiatives (TB, malaria, etc.)? Please identify specific examples.
- To what extent has the technical assistance supported field training and coordination for advocacy? What other technical assistance would have contributed to the success of the initiative? What elements of the technical assistance are being used currently or are planned for upcoming activities?
- In terms of the progress in implementing the work plan, using a scale from 1-5, how would you rank it (1 = least progress / 5 = highest progress)? What would push implementation of the work plan forward? What would maintain the momentum?
- What has slowed or held back implementation?
- How would you rank interest and commitment by AWG and others to continue with advocacy activities? What individuals and partners are essential in the process to keep the plan alive?
- What advocacy activities are you currently involved with? How is your organization planning to contribute to advocacy activities?
- As your organization's representative on the coalition, or are you authorized to commit your organization to the initiative's goals?
- What specific assistance might be helpful to improve or strengthen the cohesion and coordination of the group and its activities?
- What specific activities, resources, and commitments do you need in order to fully support AMR advocacy activities? How can the AWG assist

your program? What specific activities, resources, and commitments are you able to provide?

- How can the AWG assist your program and how you can assist the AWG in preventing/combating drug resistance in Zambia?
- Is there some area we haven't asked you about that you'd like to comment about? Do you have any other comments or are you able to elaborate on any of your input?

For journalists:

- Do you cover primarily health issues? How long have you been covering health issues? How about AMR? Probe for malaria, TB, and HIV.
- What are your main sources for health stories? Probe for malaria, TB, HIV, AMR. State specific institutions, research institutes, NGOs, specialized articles, VOA, or others (please specify). How frequently are these issues covered by your form of media (in your judgment)? Probe for daily basis, once a week, less than once a week.
- What type of story is covered most frequently? Probe for reports, analysis, commentary, investigation, other. Probe for which one they would most likely cover in relation to AMR.
- Which health issue is covered most often? Probe for malaria, TB, HIV, and AMR.
- Probe for their perspective on the Call for Action activity and AMR in Zambia. Areas of key interest and linkages to other issues such as drug quality, other infectious diseases, etc.?
- Do the media in Zambia cover the health situation in other countries of the region? Probe for malaria, TB, HIV, and AMR. What sources of such information can you name?
- What kind of training/information sharing/source access (other than press conferences) would you prefer? (By themes; journalist approaches and techniques; working with sources; promotion; relations with NGO and institutions, etc.). Probe for courses, workshops, materials, and online reporting sources in which they would like to participate.

Biographies of Team Members

Team Leader

Marisabel Sánchez, M.P.H.

Ms. Sánchez has over 15 years of experience in communication and advocacy, as a designer, manager and evaluator of programs with a focus on public health and environmental issues.

Communication

She has orchestrated corporate advertising, marketing, public relations, and risk communication programs; conducted market research studies²⁰; evaluated public awareness and behavior change programs; and implemented social marketing campaigns. Ms. Sánchez has provided clients expertise in the development and application of communication tools including promotions, trade shows, sales and customer training, newsletters, and multimedia web, print, and television media.

Ms. Sánchez is an accomplished media producer and documentary filmmaker and has won important awards including Mercury, ADDY, CPB-Best Radio Documentary Award, and the Mark of Excellence by the Society of Professional Journalists.

Advocacy

Ms. Sánchez has advised clients on effective approaches for creating policy change. She has helped companies and organizations influence public policy through effective grassroots advocacy with customized solutions, including:

- Advocacy training and consulting
- Grassroots education
- Issue-specific advocacy events and lobby-day coordination
- Grassroots organizing and network development
- Issue-campaign development and support
- Consulting around local advocacy, initiative and ballot measure campaigns
- Media advocacy
- Political campaigns
- Coalition building and resource mobilization
- Issue knowledge and strategy development
- Analysis of legislation
- Issue fact sheets and talking points
- Practices and strategy guidance documents
- Assessment and evaluation of advocacy activities

²⁰These projects included Medicare benefits for beneficiaries with diabetes and the health partnership program "Progress, Opportunities and Challenges: Proposed Conceptual Framework for Evaluating the Model Program." Please refer to: http://apha.confex.com/apha/128am/techprogram/session_3453.htm and <http://www.niams.nih.gov/hi/outreach/hppssummary.htm>

Working as a national media advocacy strategist, she has positioned clients and their issues in the public's agenda including in:

- Sustainable development
- Species and ecosystem protection
- North American Agreement on Environmental Cooperation (NAAEC)
- Value of health care
- Tax-exempt community benefits legislation
- Creating a better health care system
- Charity care, billing and collection practices
- Medicare and Medicaid
- Essential community providers
- Access and coverage
- Disaster preparedness
- Eliminating racial and ethnic disparities
- Health care workforce
- Psychiatric and substance abuse access and coverage
- Quality and patient safety
- Patient dumping
- Migrant populations (documented and undocumented)

Ms. Sánchez has secured prominent media coverage for her clients on CNN, CNN Español, Fox News Channel, CNBC, *The New York Times*, *The Los Angeles Times*, *The Washington Post*, *The Washington Times*, *The Wall Street Journal*, *People Magazine*, *Teen People*, NPR, ABC news, NBC news, The NewsHour with Jim Lehrer, Univision, and Telemundo. She also has obtained coverage for her clients in foreign press media such as *El Nuevo Día-San Juan*, *Agencia EFE*, and *La Reforma-Mexico*.

Behavioral Health Communication (BHC)

Her experience spans over 15 years, and her work has included design, management, and capacity building of a broad spectrum of health projects addressing prevention and management of large-scale programs in partnership with national stakeholders in the United States, Latin America, and the Caribbean:

- Communicable diseases: ARI, anthrax, cholera, dengue fever, hepatitis A, HIV/AIDS, influenza, malaria, measles, STDs, tuberculosis, viral meningitis, West Nile virus
- Chronic diseases: arthritis, cancers (breast, ovarian, lung, skin, colon), CVD, diabetes, and osteoporosis
- Non-communicable diseases (NCD) risk factors (obesity, physical activity, nutrition, smoking, glucose and cholesterol, blood pressure)
- Childhood immunization
- Family planning and peri/neonatal health
- Domestic violence
- Gender issues

- Mental health and substance abuse
- Water and sanitation

Currently, she is involved in design of avian flu and pandemic influenza behavior change communication programs and USAID-funded antimicrobial resistance community-based interventions.

Social Marketing

Ms. Sánchez has provided her expertise for a number of social marketing campaigns sponsored by the U.S. federal Department of Health Services including:

- *Caring for Every Child's Mental Health: Communities Together*
- *Control Your Diabetes For Life*
- *The Power to Control Diabetes is in Your Hands*
- *Addiction is a Brain Disease*
- *Keep Your Brain Healthy: Don't Use Drugs*
- *Treatment: Investing in People for Business Success*
- *¡Ojo Con Su Visión!*
- *Diabetic Eye Disease Education Program*
- *Glaucoma Education Program*
- *Low Vision Education Program*
- *¡Cuidado! ¡La diabetes y la presión arterial alta pueden causar enfermedades de los riñones! Aprenda a proteger sus riñones (Caution! Diabetes or High Blood Pressure Can Cause Kidney Disease! Learn how to protect your kidneys.)*
- *Prevention Works!*

Past and recent clients include a range of national, state and local-level associations and businesses such as AT&T, Thomason Hospital, Kaiser Permanente, San Rafael Chamber of Commerce, Olympia Health Management Alliance of New Mexico, Humane Society of the United States, Pan American Health Organization, USAID, Department of Homeland Security, National Institutes of Health, Centers for Disease Control and Prevention (CDC), Mental Health Partnerships Projects – Minot, Bismarck, and Fargo, North Dakota, and Diabetes-Hoy, the largest health consumer advocacy organization in the Caribbean and Latin America.

Dolores Briones, MSSW

Ms. Briones is a seasoned advocacy and strategist. For over 20 years she has designed and implemented advocacy strategies to meet institutional goals. She has legislative experience at the state and federal levels advising Members of Congress, political strategists and staffers. She also has experience as a public elected official for El Paso County. She has led a number of mobilization projects around issues ranging from health, environment, education and economic development.

She has provided strategic advice in advocacy and mobilization to organizations including: Annie E. Casey Foundation, Thomason Hospital, Levi Straus, the National Hispana Leadership Institute, Mujer Obrera, Region XIX Education Service Center in El Paso, North Central Regional Education Lab in the Chicago area, the Southwest Key Program in Austin, Texas, and the El Paso Hispanic Chamber of Commerce.

Advocate

Ms. Briones spearheaded a 100-member volunteer voter registration and get-out-the-vote drive that resulted in a record increase in the percent of Hispanic voter registration and was credited with deciding the election. She also researched the political, environmental and social aspects of the history of withholding and releasing water to the *colonias* in El Paso County and conceived the strategy to collect and trade irrigation rights for water hookups with the Public Service Board.

Strategic Planning

Ms. Briones counseled the El Paso Hispanic Chamber of Commerce in the development of its mission statement, objectives, and work plan for the first two years and assisted the Board of Directors with obtaining 501c-3. She also designed scholarship and selection protocols and raised \$115,000 in foundation funds for an 18-month operation period.

She has been recognized with a number of prestigious awards including: Good Housekeeping Award for Women in Government, Outstanding Young El Pasoan (first woman ever selected), *National Who's Who Among Human Service Professionals*, and El Paso's Women's Political Caucus "Political Newcomer of the Year" award.