

# Society for Family Health/Zambia Strategic Plan 2006-2011

## I. Background & Methodology

Society for Family Health/Zambia's (SFH) strategic plan is based on a careful assessment of internal and external factors related to the future of social marketing in Zambia. During a May 2006 strategic planning workshop, a core team of six managers representing different levels of and departments within the organization updated the organization's vision in terms of health outcome targets for 2011.<sup>1</sup> The core team assessed key challenges relative to the 2011 vision and identified priority activities to expand and strengthen health programs and build organizational and financial foundations. Subsequently, a draft plan was shared with a wider group of SFH staff members and finalized based on their feedback. The Government of Zambia (GRZ), non-governmental organizations, donors, SFH Board and PSI/Washington contributed to the 2006-2011 plan through individual interviews conducted during March and April 2006.

SFH's 2006-2011 strategic plan draws heavily upon previous organizational development efforts including prior strategic planning exercises, the December 2005 Results Initiative assessment and the April 2006 SFH staff survey. Since SFH's last strategic planning exercise more than 4 years ago, the organization has expanded health programming, secured new funding, added field offices and restructured the head office, strengthened systems and built capacity by recruiting and training staff members. The 2006-2011 plan builds on these efforts.

## II. SFH Identity, Mission and Core Values

### Identity

SFH is a registered not-for-profit Zambian trust in conjunction with the Pharmaceutical Society of Zambia. SFH is *both* a Zambian organization *and* an affiliate of PSI, an international social marketing organization.

Established in 1992, SFH is one of the largest non-governmental organizations in Zambia with 250 staff members and nine project offices around the country. As of April 2006, SFH markets six products to address HIV/AIDS, malaria, reproductive health and water borne diseases: *Maximum* condoms, *Maximum Scented* condoms, *Care* female condoms, *Safeplan* oral contraceptives, *Mama Safenite* insecticide-treated mosquito nets and *Clorin* home water treatment solution. Since 2002, SFH has developed and promoted the *New Start* network of voluntary counselling and testing for HIV (VCT) services including stand-alone VCT centres as well as mobile clinics.

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<sup>1</sup> The following individuals participated in SFH's May 2006 strategic planning meeting: Charles Kalonga (Program Operations Director), Brian McKenna (Business Operations Director), Yotam Tembo (Lusaka Area Manager), Cynde Robinson (Country Representative), Esnea Mlewa (Water & Malaria Program Manager), Richard Harrison (Deputy Country Representative).

## Mission

SFH's mission is to empower low-income and vulnerable Zambians to lead healthier lives in line with the Government of Zambia's health priorities. We do this through social marketing: working with both the private and public sectors to promote healthy behavior and to ensure access to quality, affordable health products and services.

## Beliefs

SFH's mission is derived from the following fundamental beliefs:

In the broadest sense, health is the greatest gift. It is a prerequisite for broader socio-economic improvement as articulated through the Millennium Development Goals. All people – regardless of race, ethnicity, tribe, nationality, religion, gender or socio-economic status have the right to full access to information, products and services conducive to leading healthy lives. SFH has the obligation to address health inequities by focusing on the poor and underserved.

Health is a public as well as a private matter. While the state has an obligation to guarantee rights to health, people may seek to realize those rights through individual initiatives in their families and civil society. Commercial techniques, such as marketing, have great potential to contribute to public health.

## Core Values

SFH core values are guiding principles and tenets that describe how the organization strives to operate:

**Accountability:** As employees of a non-profit social organization, we acknowledge an obligation to set and demand the highest standards of accountability cost-consciousness in the use of resources entrusted to us by our supporters and to be role models in this regard.

**Professionalism:** SFH employees have a professional work ethic: we are honest, dedicated to our mission and accountable for our work. We respect other SFH staff members, our partners and the people we serve. We aspire to be a hard-working, dynamic, proactive and reliable organization and we base our strategies on evidence and self-criticism for continuous improvement.

**Efficiency:** We value efficiency and timeliness at every level of our operation. We cultivate nimble, responsive and efficient systems and procedures that enable us to meet and beat deadlines and seamlessly convert ideas and decisions into action.

**Innovation:** We strive to apply innovative technical, logistical and communications solutions to the preeminent health challenges in Zambia.

**Collaboration:** We encourage teamwork, communication and participation to maximize the collective efforts of all staff. We embrace opportunities for furthering and enhancing our mission through partnerships with other organizations and community groups.

**Cultural Responsibility:** We are committed to designing and implementing all program activities in such a way as to maximize health impact while respecting and promoting Zambian culture.

### III. SFH Vision for 2011

SFH's vision statement describes what the organization hopes to achieve in five years:

#### **Vision for 2011**

By 2011, SFH will demonstrate nationally significant impact on Zambia's priority health problems including malaria, HIV/AIDS, water borne disease, and reproductive health. Salient achievements will include:

- Total annual condom market grows to 4 per capita
- 60 % of pregnant women and children under five sleep under an insecticide treated bed net (ITN)
- SFH DALYs double
- 75% of consumers reached by SFH are low income.<sup>2</sup>

The following two tables demonstrate the status of SFH programs today and projected growth five years into the future. The first table represents a critical assessment of SFH programs in 2006 relative to international standards for social marketing for health. SFH has launched one product in the past four years: *Maximum Scented* condoms. Marketing efforts for the existing products have had limited success. Although SFH brands are well-known, many barriers to correct and consistent use remain. Maximum condoms are available in less than one-third of all outlets in Lusaka. Among mothers who use *Clorin* to treat their water, less than 56 % can correctly demonstrate how to use the product.<sup>3</sup> The VCT program is promising, but limited in terms of coverage and faces considerable challenges in adhering to quality service delivery standards. Communications work has been limited in reach, narrowly focused on brand promotion objectives and haphazardly developed. Many of these limitations are related to funding gaps.

The second table illustrates the implications of the vision in terms of how SFH will expand and improve product sales, communications and health services work over the next five years. To achieve its vision, SFH will intensify, scale up and add depth to social marketing programs across four priority health areas. During the next five years, SFH will launch six or more new social marketing products. To dramatically increase consumer access to existing as well as new products, SFH will overhaul its distribution efforts and work with public sector and community channels. To motivate low-income Zambians to use SFH products consistently and practice related healthy behaviours, SFH will develop world-class communications capacity to produce multi-media campaigns and materials based both on local evidence and international experience. SFH will double the size of the *New Start* network and ensure that service providers consistently meet service delivery standards. SFH will improve access to other priority health services (e.g. STI treatment, male circumcision and injectable contraceptives) by integrating products and services into the *New Start* network and, possibly, designing a social franchise network of private health providers in Zambia.

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<sup>2</sup> Zambian consumers categorized by SES levels D & E.

<sup>3</sup> 2005 SFH tracking survey data.

### SFH Social Marketing Programs in 2006<sup>4</sup>

Health Priority	Product Sales	Communication	Health Services
STI/HIV/AIDS	XX	XX	X
Reproductive Health	X	X	
Malaria	X	X	
Diarrhoea Control	XX	X	

### SFH Social Marketing Programs in 2011

Health Priority	Product Sales	Communication	Health Services
STI/HIV/AIDS	XXxx	XXxx	Xxx
Reproductive Health	Xxx	Xx	Xx
Malaria	Xxx	Xxx	X
Diarrhoea Control	XXxx	Xxx	X

#### IV. Operating Context & Health Problems

Approximately 38 % of Zambia’s 11 million people live in urban areas. Zambia has one of the highest dependency ratios in the world with 47 % of the population under the age of 15. Only 65 % of the population is literate. Men are more likely to be literate (81.6 %) compared to women (60.6 %).<sup>5</sup> Violence against women is prevalent and accepted. More than half of all Zambian women have experienced physical abuse in their lifetime.<sup>6</sup> Christianity is an important part of Zambian culture with 75 % of the country identifying themselves as Protestant and 23 % as Catholic. There are 73 ethnic groups speaking 20 distinct languages in Zambia.

Zambia’s economy has grown at an annual rate of roughly 5 % since 2004. Although this represents an improvement compared to prior years, it is far below the level needed to achieve significant macroeconomic improvement: 8 % growth sustained over 10 years. Agriculture and copper mining drive the economy with the latter accounting for 95 % of the country’s export earnings. Zambia’s 2005 inflation rate was close to 16 %.<sup>7</sup> Severe economic hardship is a reality for most of the population with 67 % living below the poverty line. Poverty rates are higher in rural areas (72 %) compared to urban (28 %).<sup>8</sup> According to the 2002/2003 Living Conditions Monitoring Survey, more than 13 % of the population is unemployed, almost 15% are employed in the formal sector and the remainder are employed in the informal sector. The Kwacha has appreciated, on average, by 33 % since 2005. GRZ representatives report plans to further appreciate the Kwacha in 2006 from K3250 to K2500/US\$. Many speculate that 2006 appreciation may be related to the upcoming election, and therefore short-lived. In the meantime, the appreciation, combined with stagnant prices, is having a severe impact on consumer purchasing power.

<sup>4</sup> Five Xs signifies SFH doing as much as possible in this area.

<sup>5</sup> ZDHS 2001-2002

<sup>6</sup> ibid

<sup>7</sup> Price Waterhouse Coopers, “Making the right moves? The Zambian budget 2006.”

<sup>8</sup> GRZ, National Health Strategic Plan 2006-2011

The role and structure of the Ministry of Health are changing as a result of the recent dissolution of the Central Board of Health (CBOH) and ongoing reorganization linked to the Public Sector Reform Programme (PSRP) and the National Decentralisation Policy. The government has been implementing health sector reforms aimed at decentralizing resources and management authority to the district and health service delivery unit level since 1992. Challenges to these goals include a critical shortage of health workers, funding gaps, weak health facility infrastructure and shortage of basic equipment. Facilities in rural areas are particularly understaffed and less likely to have basic health commodities and equipment. The proportion of GRZ budget allocated to health has declined from 14 % in the late 1990s to 10% in 2004. Private sector health care service delivery is underdeveloped in Zambia. Nationwide, there are 1,124 government health facilities compared to 88 Mission facilities and 115 private facilities.<sup>9</sup>

## HIV/AIDS

National HIV prevalence among adults is 16 %. This national figure masks significant variability by geographic area and sex. As a province, Lusaka reports the highest prevalence rate in the country (22 %). Young women (15-19 years old) are five times more likely to be infected compared to males in the same age group. Heterosexual sex is the primary mode of transmission in Zambia. The prevalence of STIs, poverty, mobility of long-distance trucker drivers and other sub-populations, cultural beliefs and practices, widespread stigma and discrimination against people living with HIV/AIDS (PLWHA), the status of women and substance abuse all contribute to the spread of HIV/AIDS in Zambia.<sup>10</sup> High risk groups including female sex workers and transport workers account for only 5-8 % of all new infections.<sup>11</sup>

Reported condom use has decreased between 2003 and 2005. Only 49.7 % of urban males report using a condom in last sex with a non-regular partner in 2005, a decline from 54.6 % in 2003. Reported condom use with non-regular partners has also declined among urban as well as rural women. Concerns regarding condom effectiveness, sexual pleasure and stigmas contribute to low condom use rates. Less than half of all Zambians believe that condoms are “very effective” in preventing HIV/AIDS and 29 % believe that condoms suppress sexual pleasure. One third of all Zambians interviewed agree with the statement “condoms are too embarrassing to suggest.”<sup>12</sup>

Roughly 30 million condoms are distributed or sold in Zambia every year. SFH sales represent roughly one third of the total condom market. Other contributors include the government, commercial brands and social marketing brand from Zimbabwe and the government condom from Namibia. The GRZ aims to distribute 30 million free condoms in 2006. The Minister for Health is very supportive of male as well as female condom promotion strategies, including social marketing. In 2006 she encouraged SFH staff to demonstrate correct use of the female condom on national television.

Access to antiretroviral therapy is increasing but is not yet widespread. The GRZ began providing free AZT through government facilities in 2005. Since then, the government estimates it has helped 50,000 individuals access treatment (out of 200,000 in need). VCT services are provided

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<sup>9</sup> GRZ, National Health Strategic Plan 2006-2011

<sup>10</sup> GRZ, National HIV/AIDS/STI/TB Policy. June 2005.

<sup>11</sup> Shields, 2004

<sup>12</sup> Zambia Sexual Behavior Survey, 2005.

by more than 420 government health facilities as well as through several NGO programs and Mission clinics. Most of the existing VCT sites are concentrated in urban areas. Although 8 out of 10 Zambians know where to go for an HIV test, very few have been tested. Only 11 % of males and 15 % of females know their HIV status. Three fourths of Zambians cite fear as a reason for not getting tested whereas one-third of respondents mention stigma and discrimination.<sup>13</sup>

Between 1985 and 2002, the tuberculosis (TB) notification rate increased from 105 to 545 per 100,000 in Zambia. An estimated 70 % of all TB patients are believed to be HIV positive.<sup>14</sup>

## Malaria

Malaria is a leading cause of mortality in Zambia and accounts for 45 % of all hospitalizations and outpatient visits. The National Malaria Control Centre (NMCC) estimates that malaria affects 4.3 million Zambians and causes 50,000 deaths every year. Pregnant women and children under five are disproportionately affected. Malaria accounts for one out of every five maternal deaths and half of all pediatric outpatient visits at health facilities.<sup>15</sup> The spread of drug resistance, limited access to health services, the spread of HIV/AIDS and poverty have contributed to increased malaria incidence in Zambia.

Goals set forth in the government's 2006-2010 Strategic Plan for Malaria include reducing malaria incidence by 75 %. Recent program achievements likely to contribute to this goal include the revision of the national malaria drug therapy policy to support Artemisinin combination therapy (ACT), widespread distribution of free ITNs, the introduction of Intermittent Presumptive Treatment for pregnant women, indoor residual spraying in eight districts, and training of district-level health providers. Since 2000, Zambia has been awarded more than \$82 million for malaria control through the Global Fund.<sup>16</sup> These funds are supporting a range of prevention and treatment efforts including the distribution of 3 million free ITNs by the end of 2008.

Challenges to the government's national malaria targets include low rates of correct and consistent ITN use and limited access to malaria treatment drugs and related services. These obstacles are greatest in rural areas of the country. Less than a third of rural mothers sleep under a net throughout the year. Only 67 % of Zambians believe that children under 5 are at high risk of malaria. Fewer than 20 % of parents report that ITNs are affordable.<sup>17</sup>

## Reproductive Health

Zambia has one of the highest maternal mortality rates in the world. Furthermore, the maternal mortality rate is increasing from 649 maternal deaths per 100,000 live births in 1996 to 729 in 2002. Although 90 % of all pregnant women receive some antenatal care, only 43 % deliver in health facilities. On average, Zambian women have close to 6 children during their lifetime. Although contraceptive use is increasing over time, only 22.6 % of all married women in Zambia currently use modern contraceptives. Oral contraceptives are the preferred method representing

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<sup>13</sup> Zambia Sexual Behavior Survey, 2005.

<sup>14</sup> GRZ, National Health Strategic Plan 2006-2011.

<sup>15</sup> *ibid*

<sup>16</sup> MOH, A Road Map for Impact on Malaria in Zambia: A 5-year Strategic Plan. 2006-2010.

<sup>17</sup> 2005 SFH tracking survey data.

53 % of all modern method users, followed by injectable contraceptives (20 %) and male condoms (17 %). Injectable contraceptives are gaining in popularity compared to other methods.

The main reason women do not use family planning in Zambia is the lack of perceived need for a variety of fertility-related issues (e.g. desire for more children, infrequent sex, infertility, etc.). However, close to 18 % of all non-users cite concerns about methods or limited access as key barriers. For more than 1 in 10 women, opposition to family planning (by themselves, their partner or their community) is a factor preventing contraceptive use.

However, there a significant proportion of the population has an unmet need for family planning. More than 27 % of all married women reported an unmet need for family planning in 1996 as well as 2002. Unmet need is highest among younger, less-educated women in rural areas. Concerns and fears related to perceived side effects of modern methods are a critical factor contributing to Zambia's high and stable rates of unmet need for family planning.<sup>18</sup>

### Water Borne Diseases

Dehydration caused by diarrhoea is a major cause of illness and mortality among Zambian children. Poor sanitary conditions, limited access to safe water and poor hygiene practices all contribute to diarrhoea disease. Twenty % of Zambian children suffered from diarrhoea in the two weeks preceding the survey. Rates of diarrhoea are highest in Lusaka, Southern and Luapula and Eastern provinces.

Only 53 % of children suffering from diarrhoea received oral rehydration solution (ORS) and 40.9 % received increased fluids. One in five children suffering from diarrhoea receives no treatment at all.<sup>19</sup> Fewer than one in three Zambian women report that they “always” wash their hands before preparing a meal. Less than 40 % report that they “always” wash their hands after using the toilet. Among mothers using *Clorin*, less than 56 % can demonstrate how to use the product correctly.<sup>20</sup>

## V. Analysis of SFH Social Marketing Programs

### HIV/AIDS Prevention

In 2005, SFH sold 13 million *Maximum Classic* (launched in 1998) and *Maximum Scented* condoms (launched in 2004), and roughly 250,000 *Care* female condoms. Product sales are supported by mass media and interpersonal communications, although US funding restrictions have severely limited condom promotion. *Maximum* condoms are sold through a network of more than 6,000 traditional and non-traditional outlets nationwide. Non-traditional condom outlets include Ntembas, beauty parlors, bars and nightclubs. SFH works with roughly 100 wholesalers in Zambia, of which at least 12 are considered “major” retailers meaning that they serve retailers in multiple districts.

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<sup>18</sup> ZDHS, 2001-2002

<sup>19</sup> *ibid.*

<sup>20</sup> 2005 SFH TRac survey data.

Approximately 60% of all *Maximum* sales go through wholesalers. Another 20% of SFH condom sales are directly made by SFH's team of 32 sales representatives working out of 9 provincial platform offices. Recently, SFH sales representatives have increased "uplifting" of wholesaler stocks to commercial retailers in order to improve condom access and strengthen wholesaler-retailer linkages. Roughly 10% of all *Maximum* sales are made to NGOs. In 2005, SFH forged a relationship with a national distributor to maximize commercial sales to larger numbers of retailers and to allow SFH sales representatives to focus on direct sales to more focused outlets in target geographic areas. This partnership has not been as successful as hoped, and in 2006 SFH will return to a model of engaging larger numbers of wholesalers along the line of rail. Despite these efforts to strengthen condom distribution, significant gaps remain in urban as well as rural areas: less than a quarter of all urban outlets in Lusaka currently stock *Maximum*.

Since 2002, SFH/Zambia has developed and promoted the *New Start* network of VCT centers. Originally made up of two "stand alone" SFH-operated centers in Lusaka and Kitwe and two mobile clinics, SFH is expanding the network to include private and government-run clinics. In 2006 the network aims to serve 40,000 VCT clients through 4 centers in 3 cities. SFH is currently conducting feasibility assessments for integrating a range of family planning and STI services within the *New Start* network. SFH has a limited understanding of the extent to which quality service delivery standards are being met by *New Start* health providers.

Mass media and small-group interpersonal communications support condom sales and VCT service delivery efforts. However, the scale and content of SFH communications for HIV/AIDS prevention has been limited by US funding restrictions during the past few years. PEPFAR regulations preclude SFH from reaching populations other than primary target groups (e.g. female sex workers, distance truck drivers, etc.) and require a balanced promotion of abstinence, fidelity and condom promotion. As a result, SFH communications for HIV/AIDS have been limited in scope (reaching relatively small numbers of beneficiaries) and effectiveness (under-emphasizing barriers to correct and consistent condom use relative to other behaviors favored by PEPFAR.)

Within these limitations, SFH produces video dramas to increase awareness of issues related to HIV/AIDS. Four mobile video units (one boat and three vehicles) take the educational dramas to remote communities not served by television. A team of 35 outreach workers conducts small-group educational and promotional sessions with target groups such as migrant workers, truck drivers, fishermen, etc. In 2005 SFH reached 190,000 people through outreach activities. A range of posters, leaflets, billboards and print ads is designed, tested and produced in as many as 7 local languages. In 2005, SFH was granted funding to implement a youth communications program. The youth program will utilize structured outreach (interpersonal communication) to young men and women in Lusaka and the Copperbelt.

Opportunities to improve SFH's STI/HIV/AIDS programming include overhauling distribution strategies to enhance wholesaler-retailer linkages, open new outlets and improve SFH product visibility and accessibility at existing outlets. The *New Start* network is not yet meeting existing demand for VCT services and, therefore, has great potential to expand. There is a need for strengthened quality monitoring and assurance initiatives (i.e. mystery client studies and other research, regular refresher training, enhanced provider supervision and support). Scaled up, multi-

media communications, designed to address priority barriers to consistent condom use and other safe behaviors, has the potential to greatly enhance SFH's HIV/AIDS program in future.

## **Malaria**

SFH transformed its malaria program in 2002, when it launched an antenatal clinic-based program targeting pregnant women and children under-five in three of the most rural provinces of Zambia, where malaria incidence is the highest and purchasing power is the lowest. In response to the MOH's request, SFH only sells *Mama Safenite* ITNs through government clinics. By the end of 2005, SFH had expanded the Malaria in Pregnancy (MIP) program by selling *Mama Safenite* through government clinics in seven of Zambia's nine provinces. Funding for this expansion came primarily from DfID and USAID. UNICEF and the GRATM provided supplemental funding for ITN commodity support. In 2006 SFH discontinued marketing of *Permanet* ITNs by handing distribution responsibility over to a commercial partner. The NETMark project ended operations after failing to successfully market higher-priced, cost-recovery ITNs in Zambia.

In order to make its ITNs more affordable and to ensure consistency between SFH's MIP program and goals set forth in the MOH's 2006-2010 national strategic plan, SFH cut the consumer price of *Mama Safenite* ITNs by 75% from kwacha 12,000 to kwacha 3,000 (US\$1.00) in late 2005. In response to the price-cut, sales have dramatically increased and SFH stocked out of nets in March 2006. While SFH expects to receive more than 300,000 nets by the end of 2006, commodity supplies beyond this point are uncertain.

In 2005, malaria prevention began to attract increased attention from the health and development community. Key developments include a renewed interest and significant funding commitments from the World Bank and MACEPA – an initiative funded by the Bill and Melinda Gates Foundation – to develop and support the country's five-year national strategic plan. As a key implementing partner in the delivery of ITNs and a significant contributor to the development of the strategic plan, SFH expects to receive some support from the MoH to scale-up its MIP program and has submitted proposals and budgets that await approval.

In addition to the delivery of subsidized *Mama Safenite* nets through government health centers to pregnant women and children under five, the MOH plans to deliver three free (short-lasting) ITNs to every household in Zambia by the end of 2008. Although sales of *Mama Safenite* are likely to be affected by this initiative, SFH plans to maintain and expand its program in order to ensure its target groups are able to access affordable, high-quality ITNs. As of early 2006, *Mama Safenite* is the only long-lasting ITN available to Zambians at an affordable cost.

Opportunities to strengthen SFH's malaria program in the future include expanding distribution of *Mama Safenite* beyond government clinics or marketing a second, subsidized ITN product to other target groups e.g. PLWHAs, rural men and the elderly. Communications can play a significant role in addressing barriers to correct and consistent use of ITNs. In addition, there is potential for SFH to use social marketing techniques to improve access to malaria treatment e.g. developing a pre-packaged pediatric malaria treatment product and developing communication campaigns to encourage correct treatment practices. The future success of SFH's malaria program depends largely on the extent to which SFH can position itself as a supportive partner to the NMCC.

## Reproductive Health

After ten years of marketing *Safeplan* oral contraceptives, SFH updated the packaging in 2005. The organization aims to sell nearly 1,000,000 cycles of *Safeplan* through a variety of private, public and community channels including government community-based distributors (CBDs). Young women with an unmet need for spacing are the primary target group for *Safeplan* marketing efforts. Since levels of unmet need are greatest in rural areas, SFH's reproductive health program focuses on serving these communities as well as low-income women in urban areas. SFH discontinued social marketing of foam tablets in response to insufficient consumer demand and donor support.

SFH employs four dedicated Medical Detailers who are responsible for training and supporting various *Safeplan* providers including private chemists and CBDs. Limited communication resources support interpersonal outreach efforts as well as promotional materials designed to motivate the trade as well as consumers. In 2005, SFH launched a new community initiative, *Circle of Friends*, whereby satisfied *Safeplan* users recruit non-users. SFH's reproductive health program has been constrained by low levels of donor support for family planning. Relative to HIV/AIDS and malaria, funding for reproductive health work in Zambia is severely limited. In 2006, SFH's annual budget for communication to address barriers to reproductive health is less than \$70,000. Commodity stock-outs are common as SFH has never been able to secure sufficient funding or in-kind commodity contributions to meet consumer demand for *Safeplan*.

Opportunities to strengthen SFH's reproductive health program include increased marketing of *Safeplan*, launching new higher-priced and potentially cost-recovery products to help cover commodity funding shortfalls, and integrating RH products into New Start or a network of private clinics offering high-quality, affordable RH services (i.e. a social franchise). Communications, aimed at addressing concerns about side effects and other barriers, has the potential to motivate Zambian women to use *Safeplan* and other modern family planning methods.

## Water

SFH implements the most successful social marketing water program in the PSI international network. No other country program has achieved similar results as defined by sales of a social marketing home water treatment product. Despite a limited marketing budget, SFH sells close to 2 million bottles of *Clorin* every year in Zambia. Low-income, rural children under-five and their families are the primary target group for *Clorin*. SFH sells *Clorin* through a variety of commercial and public channels, including the government's district health centres. SFH is in the process of outsourcing *Clorin* production to a local company, Pharmanova, and modifying the product's packaging/container to improve consumer access to a consistently high-quality product. This decision responds to recommendations made by the Centre for Disease Control during a 2005 program appraisal exercise.

Like malaria and reproductive health, SFH's budget for the water program has been constrained. During the past four years, communications have been limited in scale and focused on brand promotion objectives. Pending improved funding for water, SFH could implement multi-media communications campaigns to motivate a range of safe hygiene practices, including but not limited to the correct and consistent (year round) use of *Clorin*. Expanded *Clorin* marketing may

also be supported by the integration of new diarrhoea control products e.g. oral rehydration solution (ORS) with zinc, and related services.

## VI. Organizational Development

Since its inception in 1992, SFH has grown to more than 200 employees working in nine provincial offices (platforms) throughout the country. To support this growth, SFH has modified its organizational structure, developed operating systems and built technical and management skills. Fundraising, recruitment, assistance from expatriate Advisors and consultants, organizational assessments and formal and informal skill building efforts have all contributed to SFH's organizational development to date. The following table summarizes key organizational development efforts over the past eight years:

<b>Activity</b>	<b>DATE</b>
PRISSM internal assessment	1998
Strategic planning exercise	1998, 2000, 2002, 2006
Employee Manual developed	1999
Employee performance appraisal system initiated	1999
Employee health care scheme introduced	2000
Employment Manual revised	2000
Training program implemented including formal courses, cross-visits, on the job learning	2000 ongoing
HIV/AIDS in the Workplace program initiated	2002
Human Resources Database created	2002
Sexual Harassment policy established	2003
Recruitment procedures revised	2003
HIV/AIDS (ARV) Policy implemented for all employees	2004
Staff Morale Surveys	2004, 2006
Training & Evaluation Manager recruited	2005
Human Resources Training Policy finalized	2005
Organizational re-structuring	2005
Training needs assessment (for all staff) conducted	2005
Performance appraisal system revised	2005/06
Compensation packages updated based on local survey findings	2006
Results Initiative organizational assessment	2005

As of 2006, SFH's main organizational achievements include restructuring departments to support expanded programming and facilitate internal communication. This included the establishment of: provincial "platform" offices with sales and communication responsibilities, two Regional Field Managers to increase field/HQ communication, a centralized procurement function and the consolidation of Communications, Marketing, Sales and Research functions together under one Senior Manager. SFH is in the process of empowering mid-level Managers by delegating budgetary and program responsibilities.

Since 2002, SFH has gained more than 40 full-time, middle manager level employees. Of these, 25 were promoted from within. There has been significant turn-over at senior levels of the organization as well. Only 2 members of the 2006 SFH senior management team (SMT) were members of the team in 2003. Since 2004, 11 Zambian staff members have attended international conferences, training workshops or participated in visits to other social marketing programs. Consultants, expatriate Advisors, and the recruitment of new Zambian staff are helping build SFH's capacity in key areas including financial management, communications, health services, research and human resource management. One example of the impact of these efforts is the increase in SFH's OFOG audit score from 62 points to 85 points between 2005 and 2006.

Remaining organizational development challenges include developing the next generation of Senior Zambian Managers, further strengthening organizational systems including procurement and financial management, building technical capacity in medical expertise/health service delivery, new program areas, communications, research and financial management, and improving employee morale.

The results of an April 2006 staff survey conducted to prepare for the strategic planning exercise reflect high-employee expectations and discontent within the organization. Despite a recent 20% increase in SFH salaries and generous benefits (the highest in the region compared to other PSI programs in the region), SFH staff members identify insufficient salaries as one of their primary concerns. Other organizational challenges identified through the staff survey include poor staff motivation and discipline.

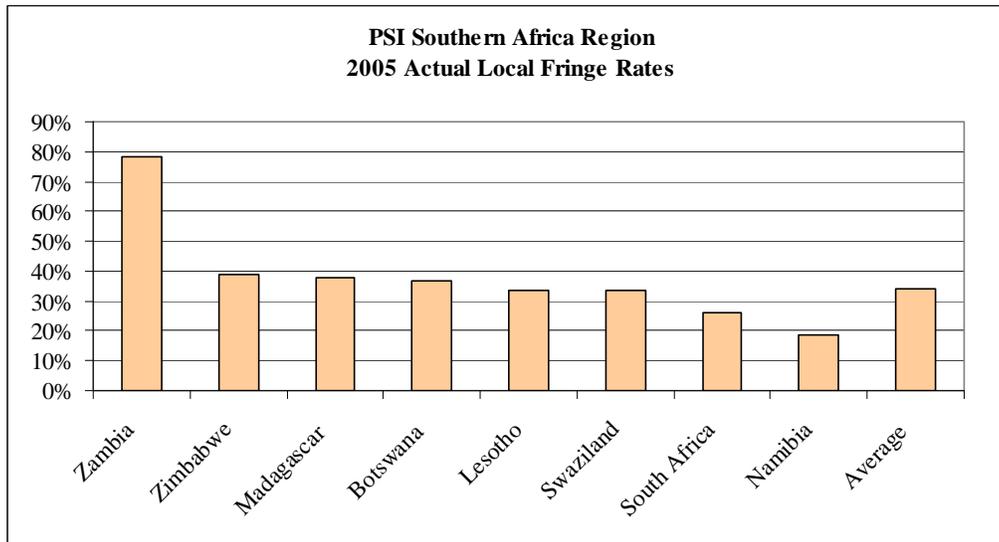
## VII. Financial analysis

Between 2001 and 2006, SFH's annual operating budget more than doubled from \$5.2 million to over \$12 million. USAID funding accounts for a large portion of this increase: during the same time period USAID annual support to SFH increased from \$3.36 million to \$7.79 million. Other donors who have contributed to the growth of SFH's annual budget include KfW, DFID, the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and PSI. Since 2001, SFH's operational costs have increased as a result of the establishment of nine provincial offices, the scaling-up of the malaria program and the development and operation of SFH-operated VCT clinics.

The macroeconomic environment has significantly contributed to the increase in SFH costs. Since 2001, annual inflation has averaged more than 18% in Zambia. In addition, between May 2005 and May 2006, the Zambian kwacha has appreciated against the US dollar by more than 35%. This means that all kwacha-denominated expenses cost SFH 50% more than they did 12 months ago. Current indications are that the government plans to appreciate the kwacha even further against the dollar -- at least until the elections are held at the end of 2006.

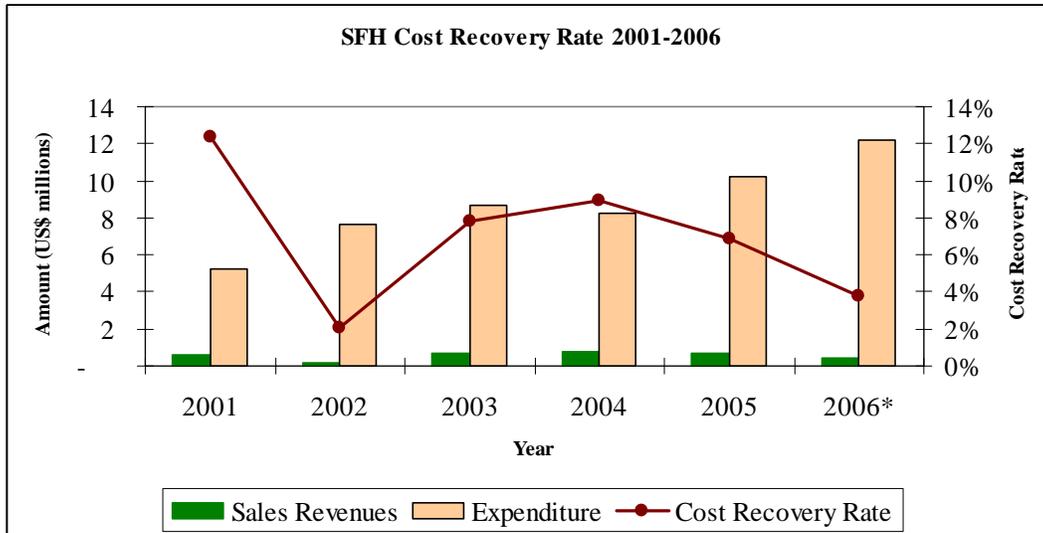
Recurrent costs, especially labor and benefits, are excessively high. SFH has one of the highest labor burdens in the PSI network as a percentage of total expenditures. In 2005, SFH staff salary and benefits account for roughly 30% of the total budget, or more than \$3 million. Significantly contributing to this was the exceptionally high fringe rate SFH paid its local employees in the

same year: 78%. This was more than double the average for PSI affiliates in the region (34%), as reflected by the graph below.



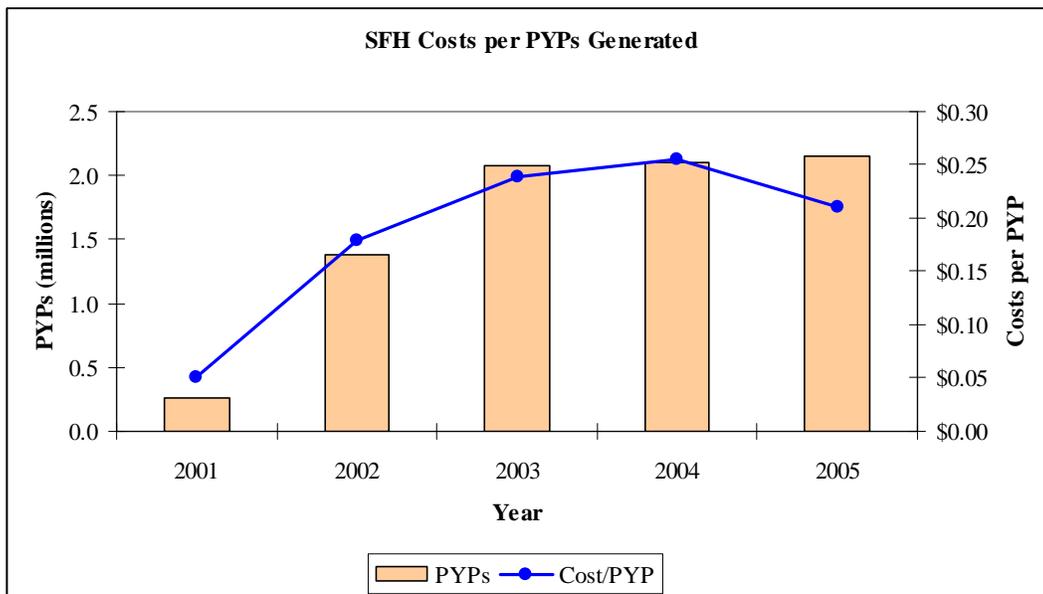
In 2006, SFH is supported by 11 active grants. Of these, only four are likely to remain active in 2007: USAID/PEPFAR funding for all four health program areas to varying degrees, KfW support for VCT expansion, GFATM Round Four funding for the malaria program and PSI support to explore the feasibility of male circumcision. Since 2001, SFH’s reliance on USAID has decreased from 70% to 64% of total annual expenditure. However, unless SFH is able to secure large grants from other donors, this dependency on USAID is likely to increase in future years.

Program income – revenue generated by the sale of social marketing products and services – increased by 9% between 2001 and 2005. It is projected to fall in 2006 due to a 75% reduction in the consumer price of *Mama Safenite* ITNs. In 2005, sales of *Mama Safenite* contributed more than 40% of all program income generated by the program. Other products that contribute significantly to program income include *Clorin* and *Maximum*. SFH’s cost recovery rate (sales revenues as a percentage of expenditure) averaged 8% over the past five years. As the following graph portrays, the cost recovery rate is projected to fall to 4% this year, largely as a result of the lower consumer price of *Mama Safenite* ITNs.

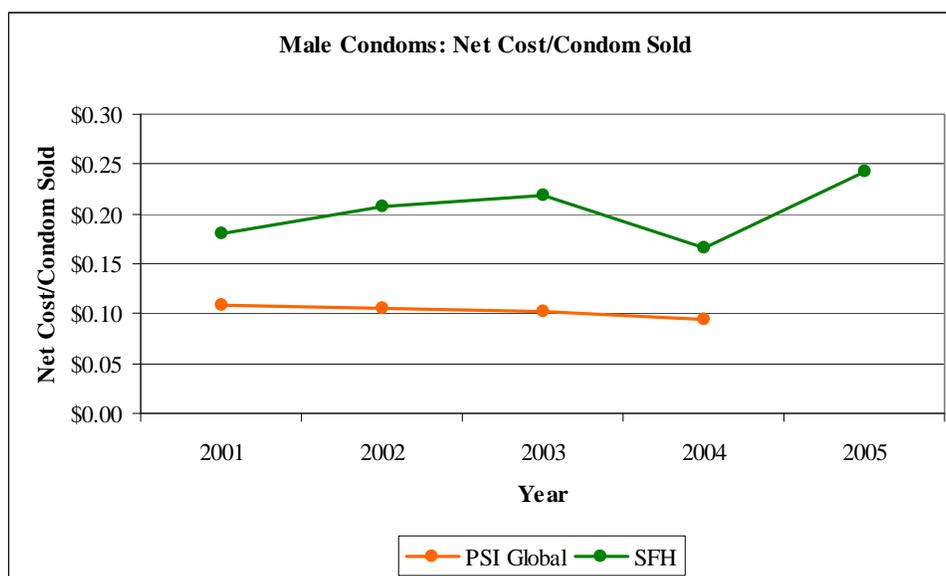


\* Based on projected 2006 expenditure & program income.

Overall, in the past five years, SFH's cost per PYP (person years of protection) has increased from \$0.05 in 2001 to \$0.21 in 2005. These trends reflect the negative impact of inflation and exchange rates combined with increasing program expenditure to reach rural communities with products such as *Mama Safenite* and provide high-quality VCT services.



SFH's cost per condom sold has increased significantly from \$0.18 in 2001 to \$0.24 in 2005. As depicted in the graph below, it is well above the international average for PSI. Costs per unit sold for *Clorin*, *care* and *SafePlan* have fallen whereas they have increased significantly for VCT services. *Mama Safenite* costs per unit sold have decreased since 2001, but have seen a significant increase since 2003 – when they were \$5.54 – to \$12.30 in 2005. This is due to the scaling up of SFH malaria operations from two to seven of Zambia's nine provinces.



Donor assistance for SFH’s HIV/AIDS programming is expected to be sustained or increase over the next five years. Funding for malaria is less certain. Although USAID funding for malaria is expected to continue through 2010, it will favor commodities as opposed to operational expenses. Supplemental funding for operations and commodities to support *Mama Safenite* – currently sourced from GFATM – is less secure. SFH’s reproductive health and control of diarrhoeal disease programs are particularly vulnerable as donor support for these areas is scarce. USAID is the only donor providing direct funding to NGOs for these health areas and their budgets for RH and CDD are limited.

Two trends are likely to contribute significantly to SFH’s future funding vulnerabilities: the European donor preference to provide direct “program” support to the GRZ instead of “project” support to NGOs, and USAID restrictions on HIV/AIDS prevention programming. The GRZ may become a potential donor for SFH in the future as European donors move towards delegating sector-wide funding decisions to the Ministries of Finance and Health.

To address the shortage of sufficient donor support for key commodities – especially reproductive health products – SFH will launch new, cost recovery products (with consumer prices set to cover basic commodity and packaging costs at a minimum). SFH expects program income to support an increasing proportion of program costs for under-funded areas including RH and CDD.

### VIII. External perceptions

In April 2006, SFH asked 15 partner organizations to assess strengths and weaknesses of its social marketing programmes and give advice for future programming. Representatives from the Ministry of Health, USAID, DFID, KfW, Health Communication Partnership, JHPIEGO, Church Health Association of Zambia, FHI, UNFPA and the Royal Netherlands and American Embassies participated. The results of the April 2006 stakeholder interviews are described below.

SFH is well respected by its government, NGO and donor partners. The organization is credited with increasing consumer access to condoms, ITNs and home water treatment solution. SFH is “easy to work with,” “responsive to partners” and “gets the job done.” Its strengths, as perceived by its partners, include an extensive **distribution network**, creative **advertising capacity** and **established brands**, the ability to work through the **private sector**, funding, and **link with PSI’s** international network. Perceived weaknesses include a narrow program **focus on promoting brands instead of behaviors**, **insufficient coordination with the GRZ**, inconsistent **quality and limited reach of *New Start***, low-energy implementation (**weak work ethic and “tired” program approaches**), and high and unnecessary **costs**. Stakeholders describe SFH as **overly reliant on sales data** for monitoring and evaluation data and believe the organization could do more to use research and strengthen field-level monitoring.

Partners encourage SFH to address these perceived weaknesses in the future. There is widespread support for SFH to **re-energize and intensify its HIV prevention program** and maintain a focus on condom promotion. Other program recommendations include developing more **comprehensive malaria and reproductive health programs** and exploring whether social marketing can be applied to improve nutrition (without re-/launching a product.) There is some support for SFH to explore the potential to launch higher priced products with potential to help subsidize under-funded programs. **Funding is identified as the primary threat** to SFH’s future success, in particular SFH’s reliance on US funding given the current policy restrictions and the uncertainty of post-PEPFAR funding levels.

To facilitate SFH program growth and improvement, partners encourage the organization to play a greater **advocacy role** in the future. In particular, they would like SFH to advocate for increased attention/funding **for HIV prevention and reproductive health** by sharing SFH research findings and program lessons with GRZ and donors and participating in national-level coordinating bodies such as the NAC’s Technical Working Groups. Donors encourage SFH to articulate its **sustainability approach** and **capacity building objectives**.

## IX. Strategic SWOT

During the May 2006 strategic planning workshop, SFH staff discussed and ranked organizational and programmatic issues relative to the vision. Analysis of programs by health area, research and communication functions, organizational development and historical expenditure and revenue data and projected financial risks were all incorporated into the strategic SWOT below. Issues identified as highest importance represent priorities to be addressed through the implementation of SFH's strategic plan.

<b>STRENGTHS</b>	<b>WEAKNESSES</b>
<p><i>Highest importance</i></p> <ul style="list-style-type: none"> <li>• Positive reputation among GRZ, donor &amp; NGO partners</li> <li>• Social marketing expertise: only group applying commercial marketing techniques to health in Zambia</li> <li>• National distribution network</li> <li>• Links to international PSI network (funding, technical assistance, program models, etc.)</li> </ul> <p><i>Medium importance</i></p> <ul style="list-style-type: none"> <li>• Partnership with GRZ to distribute <i>Mamasafenite</i> and other products through public clinics</li> <li>• VCT approach, including mobile clinics</li> </ul>	<p><i>Highest importance</i></p> <ul style="list-style-type: none"> <li>• Funding gaps (condom promotion, ITN commodities, RH, CDD)</li> <li>• High recurrent costs</li> <li>• Limited reach, “stale” communications</li> <li>• Gaps in program coverage &amp; targeting</li> </ul> <p><i>Medium importance</i></p> <ul style="list-style-type: none"> <li>• Slow, inefficient internal systems (procurement, accounts, approvals etc.)</li> <li>• Insufficient use of research to inform programs (define media mix, identify target groups, etc.), monitor field-level operations and evaluate impact</li> <li>• Staff morale &amp; work ethic</li> <li>• <i>New Start</i> quality &amp; reach limitations</li> <li>• Skill gaps (medical/service delivery expertise, communications &amp; research)</li> </ul>
<b>OPPORTUNITIES</b>	<b>THREATS</b>

<p><i>Highest importance</i></p> <ul style="list-style-type: none"> <li>• Donor &amp; GRZ support for HIV/AIDS and malaria work</li> <li>• High levels of unmet consumer demand for injectable contraceptives &amp; VCT</li> <li>• Market supports cost recovery/enterprise fund products (e.g. contraceptives)</li> </ul> <p><i>Medium importance</i></p> <ul style="list-style-type: none"> <li>• Increasing access to anti-retroviral drugs increases consumer demand for VCT services</li> <li>• GRZ becomes potential donor as a result of basket funding, SWAP, etc.</li> </ul>	<p><i>Highest importance</i></p> <ul style="list-style-type: none"> <li>• Insufficient funding to sustain SFH's planned growth (most vulnerable: CSM, malaria, RH &amp; Water)</li> <li>• Further appreciation of the Kwacha, inflation and high transportation costs limit programming</li> </ul> <p><i>Medium importance</i></p> <ul style="list-style-type: none"> <li>• Widespread distribution of condoms &amp; nets limits SFH effectiveness</li> <li>• Condom use decreases due to "disinhibition effect" of increased access to ART and male circumcision and increased emphasis on A&amp;B</li> <li>• U.S. funding restrictions on HIV prevention programming increase</li> <li>• Relationship with the Government deteriorates</li> <li>• Opposition (to condom promotion) from religious and other community-level groups limits HIV/AIDS prevention work</li> </ul>
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## Threat Analysis

During the May 2006 workshop, senior managers analyzed threats in terms of probability (“What is the likelihood that this threat will materialize into a real problem for SFH?”) and strategic importance (“If the threat becomes a reality, to what degree would it prevent SFH from achieving the vision?”). As the following matrix highlights, the most significant threats to SFH’s vision include funding gaps and further macro-economic decline.

<b>PROBABILITY</b>				
<b>STRATEGIC IMPORTANCE</b>		<b>LOW</b>	<b>MEDIUM</b>	<b>HIGH</b>
	<b>LOW</b>			
	<b>MEDIUM</b>	Relationship with the Government deteriorates  Opposition from religious and community limits HIV/AIDS prevention work	Condom use decreases due to disinhibition effect of increased access to ART and male circumcision and increased emphasis on A&B  U.S. funding restrictions on HIV prevention programming increase	Widespread distribution of condoms & nets limits SFH effectiveness
	<b>HIGH</b>		Further appreciation of the Kwacha, inflation and high transportation costs limit programming	Insufficient funding to sustain SFH’s planned growth

## X. Strategic Themes

Based on an analysis of the current internal and external situation relative to the vision, SFH identified several strategic objectives related to maximizing health impact, developing organizational capacity, and improving the financial viability of social marketing in Zambia. To achieve its vision, SFH will draw upon internal strengths and external opportunities to address internal weaknesses and minimize external threats.

### **Maximizing Health Impact**

To contribute to a growth in the total condom market to 4 per capita and help the GRZ achieve national HIV/AIDS goals, SFH will intensify, scale up and add depth to its HIV/AIDS prevention program. SFH will **overhaul condom distribution strategies** to identify new outlets and increase the visibility and accessibility of male and female condoms in underserved urban areas as well as rural parts of the country. **New Start will be expanded** in partnership with clinics operated by other partners (but supported by SFH to adhere to quality standards for VCT). SFH will **redouble efforts to meet and sustain service delivery standards** within the New Start network by increasing the use of research to identify quality gaps and addressing gaps through increased refresher training, supervision and provider support. SFH will explore the feasibility of integrating **new products and services** into the program including pre-packaged therapy for STIs, and male circumcision services. To support this vision, SFH will raise funds to work with communities outside the primary target groups approved by USAID.

Over the next five years, SFH will scale up malaria programming. Specifically, SFH will **expand the MIP program**, launch new initiatives designed to **increase access to quality, affordable malaria treatment** and **integrate malaria with HIV/AIDS and water programs**. For example, sales of Mama Safenite will be linked with sales of Clorin at the health center level. Training for government health providers and CBD agents will be expanded to promote a range of inter-related malaria, HIV/AIDS and control of diarrhoea disease messages. SFH will **coordinate closely with the NMCC** to ensure that all social marketing activities (current and planned) appropriately support national priorities.

To improve low-income Zambian women's access to modern contraceptives, SFH will **amplify Safepan marketing, launch at least two new family planning methods**, and strengthen private health provider capacity to deliver high-quality, affordable reproductive health products and services. SFH will **train New Start providers to offer Safepan** and other RH methods. In addition, SFH will explore the viability of working with additional private providers in Zambia to establish and support **a social franchise**.

SFH will **expand and integrate Clorin marketing** into a broader set of appropriate hygiene and related MCH and HIV/AIDS messages. SFH communication to promote *Clorin* and training for health center staff will be expanded to promote a range of good hygiene practices including proper hand washing and storage of treated water. SFH will increase distribution and promotion of *Clorin* by working more closely with a greater number of government health providers and outreach workers. SFH will also explore the feasibility of marketing an ORS with zinc product.

All of the above areas will be supported by **increasingly professional communications interventions** that utilize mass, middle and interpersonal channels. Mass media resources will

contribute disproportionately to HIV/AIDS, malaria and water program objectives. SFH will use a mixture of **generic as well as branded productions to reduce stigma, increase perceived risk, and address other priority barriers** for HIV/AIDS prevention and malaria in particular. At the same time, SFH will **improve the quality and increase the reach of interpersonal communications** by redoubling training efforts and regularly updating outreach materials. Communications will be more systematically developed, using research and other sources of information to guide the design and targeting of locally appropriate and effective campaigns and materials.

SFH will **do a few large-scale quantitative studies well** over the next five years. For example, tracking surveys will be conducted for at least two health areas, but data may be collected bi-annually as opposed to every year. SFH will **increase the use of mystery-client studies, in-depth interviews and other qualitative techniques** to better understand complex behavioural patterns and assess the impact of program interventions. Secondary analysis of research conducted by other organizations (2005/6 DHS, 2005 ZBSS, etc.) will also inform SFH programming decisions. SFH will **make better use of research** over the next five years by encouraging program staff to help articulate study objectives, integrate findings into marketing decisions and disseminate results to partner organizations.

### **Developing Organizational Capacity**

To support expanding and increasingly complex health programs, SFH will build management and technical skills, improve internal morale, cultivate efficient systems and strengthen partnerships with the government and other key stakeholders. SFH will **develop middle managers** by creating opportunities for them to participate in high-level program discussions, mentoring and skill building activities. At the same time, the organization will continue to **recruit talented staff** to fill capacity gaps in the areas of medical expertise, communications, research and new program areas such as STI management. **Consultants and Expatriate Advisors will work to transfer skills to Zambian counterparts** and be evaluated accordingly. SFH will develop and update a position paper articulating the organization's approach to capacity building and related objectives and targets including whether and how the role and number of expatriates will change in the future.

Senior management recognizes the importance of nurturing an organizational culture that fosters professionalism, efficiency, innovation and other core values. Over the next five years, SFH will **increase internal communication** between offices (field and headquarters), departments, and levels of SFH. Program managers will **increase visits to the field**, including smaller and more remote platform offices. Managers will regularly discuss the organization's priorities (e.g. as articulated in the mission, vision and core values) with staff at every level and intensify efforts to recognize performance through supervision, performance feedback and low-cost employee recognition and motivation efforts. SFH will **strengthen financial management, procurement and MIS functions** to allow the organization to operate in a more nimble, responsive and efficient manner.

To improve relations with partners, SFH will **contribute to sector-wide forums and proactively support government at district and national levels** by increasing communication with DHMCs,

NAC, and NMCC. SFH will advocate for increased donor support for priority health areas including HIV/AIDS prevention, malaria and reproductive health. Toward this goal, SFH will more widely **disseminate research findings and program lessons** to donor and GRZ counterparts. Zambian staff will be encouraged to develop and strengthen contacts with GRZ. SFH will **partner with other NGOs** serving priority target groups to enhance program effectiveness.

### **Strengthening Financial Viability**

To achieve nationally significant health impact in four health areas, SFH will increase and diversify donor support, maximize program income and cut costs. To support an annual program value of \$15 million by 2011, SFH will **aggressively scale up fundraising** efforts targeting current as well as potential bi-lateral, multi-lateral and foundation donors. SFH will increase advocacy efforts by documenting and disseminating SFH research findings and related program experiences to donors and policy makers. Given the likelihood that GRZ becomes a potential donor in the future, SFH will **reassess opportunities to better align program activities with government priorities**, and actively contribute to national level coordinating mechanisms such as the NAC and NMCC Technical Working Groups. SFH's fundraising objective will be to secure sufficient commodity and operational support to facilitate significant program growth in all four health areas.

Sales revenues will increase and be reinvested into programs to complement donor funding. With support from PSI's Enterprise Fund, SFH will capitalize on opportunities to **launch cost-recovery products** in cases where latent consumer demand for private sector health products exists (e.g. injectable contraceptives, pre-packaged paediatric malaria treatment, etc.). Consumer prices for these products will be set to cover the cost-of-goods-sold and reduce reliance on donor support for commodities. SFH will also regularly **assess consumer pricing levels for other, more subsidized products** to identify opportunities to increase program income without jeopardizing consumer access.

Over the next five years, SFH will **cut and maintain recurrent costs** to a level consistent with the average for PSI programs in the region. Salaries, benefits and ODCs will be reduced to improve program efficiency. The organization will routinely **monitor and analyze costs** to identify potential cost saving opportunities. **Strengthened internal controls and financial management systems** will also contribute toward this goal.

### **Strategic choices**

SFH's 2006-2011 strategic plan includes decisions **NOT to expand in a number of areas**. During the May 2006 strategic planning exercise, SFH staff considered and rejected several potential new social marketing products including: **insecticide treated curtains, malaria repellent, implant contraceptives, IUDs and additional water treatment products** including tablets and sachets. SFH will not actively seek funding to add new programs in the areas of **nutrition, ART or other HIV/AIDS care and support work**. These decisions are based on analysis of SFH current program gaps, SFH's core competency and competitive strengths relative to partners, as well as national health priorities in Zambia. The following matrices summarize objectives, indicators and main activities to: maximize health impact; develop organizational capacity and strengthen financial viability over the next five years.

<b>Maximize Health Impact</b>		<b>Indicators (by 2011)</b>
		<ol style="list-style-type: none"> <li>1. DALYs double between 2006 and 2011</li> <li>2. Population-based evidence of behaviour change among the poor and correlation with exposure to SFH programming in at least one health areas</li> <li>3. 75% of consumers reached by SFH are low income (e.g. D &amp; E socio-economic levels)</li> <li>4. Total annual condom market of 4 per capita</li> <li>5. 50% of target groups learned their HIV status within last 12 months</li> </ol>
<b>Objectives</b>	<b>Indicators</b>	<b>Activities</b>
<b>Intensify, scale up and add depth to HIV/AIDS prevention programming</b>	<ol style="list-style-type: none"> <li>1. No male or female condom stock-outs.</li> <li>2. Male and female condom sales increase by at least 20% annually.</li> <li>3. 80% of urban outlets and 60% of rural outlets stock <i>Maximum</i> condoms.</li> <li>4. 100,000 clients counselled and tested for HIV at New Start clinics annually, of which 25% are rural.</li> <li>5. # clients seen for preventive services (STI treatment, male circumcision) at SFH-supported clinics increases.</li> </ol>	<ol style="list-style-type: none"> <li>1. Overhaul condom distribution mechanisms: scale up uplifting, direct sales and creation of new non-traditional outlets in urban areas by SFH sales agents and strengthen wholesaler/retailer linkages..</li> <li>2. Increase condom outlets in rural areas.</li> <li>3. Implement comprehensive multi-media communications to address stigma and other key barriers and motivate range of prevention behaviours (knowing one's HIV status, AB and consistent condom use)</li> <li>4. Expand VCT networks: add partner-operated (and SFH supported) VCT clinics to the <i>New Start</i> network; and strengthen referrals.</li> <li>5. Implement comprehensive quality assurance plan for <i>New Start</i> (hire senior Zambian medical technical specialist, increase post-training supervision, support, mystery client studies, regular refresher training, etc.) and balance w/ incentives to keep providers motivated (while managing expectations).</li> <li>6. Launch and market pre-packaged STI therapy kit/s, pending successful feasibility findings.</li> <li>7. Launch and introduce male circumcision services, pending successful feasibility findings.</li> </ol>
<b>Scale up malaria programming</b>	<ol style="list-style-type: none"> <li>1. <i>Mama Safenite</i> sales increase by at least 35% annually.</li> <li>2. PPT sales increase.</li> <li>3. 60% of PWUF sleep under an ITN.</li> <li>4. 80% of rural households own at least one ITN.</li> </ol>	<ol style="list-style-type: none"> <li>1. Position SFH as key partner to NMCC, willing and able to support all national malaria priorities (including free ITN distribution if needed.)</li> <li>2. Implement comprehensive multi-media communications to address barriers to consistent use of ITNs among pregnant women and children under 5.</li> <li>3. Link <i>Clorin</i> and <i>Mama Safenite</i> ITN sales at rural Health Centres.</li> <li>4. Expand subsidized ITN distribution to include community-based distributors and private channels.</li> <li>5. Launch and market pre-packaged malaria treatment (PPT) for children under 5, pending successful feasibility findings.</li> </ol>
<b>Expand access to RH products for poor women</b>	<ol style="list-style-type: none"> <li>1. CYP increases by 20% annually.</li> <li>2. 80% of traditional ethical outlets stock SFH RH products.</li> <li>3. RH consultations through SFH-supported clinics (<i>New Start</i> and others) increase annually.</li> </ol>	<ol style="list-style-type: none"> <li>1. Increase traditional outlet sales, with emphasis on chemists and private clinics.</li> <li>2. Develop and support a network of private health providers offering high-quality, affordable RH services (social franchise), pending successful feasibility findings.</li> <li>3. Develop communication campaigns/interpersonal modules to address concerns regarding side effects and other barriers to modern method use.</li> <li>4. Launch at least 2 new products (injectable, cost-recovery OC and/or emergency contraception).</li> <li>5. Advocate for ability to sell RH products through drug stores.</li> <li>6. Integrate RH products and services into <i>New Start</i>.</li> </ol>

<p><b>Integrate <i>Clorin</i> marketing into broader CDD program</b></p>	<ol style="list-style-type: none"> <li>1. <i>Clorin</i> sales increase by at least 15% annually.</li> <li>2. Sales of new ORS with zinc product increase annually.</li> <li>3. 50% of households treat water consistently (and throughout the year.)</li> <li>4. 90% of mothers demonstrate correct use of <i>Clorin</i>.</li> <li>5. 60% of mothers comply with appropriate hand washing and water storage practices.</li> </ol>	<ol style="list-style-type: none"> <li>1. Develop and implement behaviour change communications, including development of <i>Captain Clorin</i> as national icon, for multiple target groups to motivate correct/consistent use of <i>Clorin</i>, regular hand-washing and proper storage of treated water.</li> <li>2. Develop and launch ORS with zinc product pending successful feasibility findings.</li> <li>3. Broaden training program to address a range of appropriate messages on good hygiene techniques and reach a greater number of rural Health Centre staff.</li> <li>4. Link <i>Clorin</i> and <i>Mama Safenite</i> ITN sales at rural Health Centres.</li> <li>5. Collaborate with partners to incorporate SFH CDD products into home-based care kits and train home-based care-givers in appropriate BCC messages related to hygiene.</li> </ol>
<p><b>Revitalize, intensify and increase exposure to communications</b></p>	<ol style="list-style-type: none"> <li>1. Coverage and exposure indicators for mass media and IPC increase annually.</li> <li>2. Assessments (of select interventions) reflect SFH communications are well-understood and effective.</li> </ol>	<ol style="list-style-type: none"> <li>1. Develop in-house capacity to design, develop and produce first-rate communications.</li> <li>2. Implement well targeted, mid-level and mass media communications that add depth to brand promotion by addressing barriers to sustained behaviour change (for HIV/AIDs, malaria and other health program areas pending funding).</li> <li>3. Increase quality and coverage of IPC through better training &amp; support: develop and update modules and related tools regularly to address priority barriers.</li> <li>4. Use research to determine appropriate media mix, to target low income communities, and to manage communications decisions.</li> <li>5. Foster communications “thinking” at every level of the organization: increase use and quality of creative briefs and other program staff contributions to communications.</li> </ol>
<p><b>Increase use of evidence in SFH programming</b></p>	<ol style="list-style-type: none"> <li>1. All program managers can demonstrate specific changes to marketing mix based on research department outputs annually.</li> <li>2. Dashboards for at least 1 program areas updated annually.</li> </ol>	<ol style="list-style-type: none"> <li>1. Build in-house quantitative and qualitative research capacity.</li> <li>2. Introduce use of research brief.</li> <li>2. Conduct TRaC surveys in at least one health area annually.</li> <li>3. Present and articulate research findings to users and relevant external parties.</li> <li>3. Incorporate use of multivariate analysis of TRaC and other data for HIV and malaria.</li> <li>4. Increase use of qualitative studies to gain insights regarding consumer barriers and to assess impact of specific interventions (e.g. concurrent partnerships and VCT).</li> <li>5. Incorporate socio-economic classification into research program.</li> <li>6. Ensure that appropriate questions are included in DHS, ZSBS and other key external research studies</li> </ol>
<p><b>Builds on / Takes advantage of:</b></p>		<p><b>Addresses:</b></p>

<b>Strengths</b>	<ul style="list-style-type: none"> <li>-Positive reputation among partners</li> <li>-Only group applying commercial marketing techniques to health in Z.</li> <li>-National distribution network</li> <li>-Links to PSI: TA, funding, etc.</li> <li>-Partnership w/ GRZ for malaria work</li> <li>-VCT approach including mobile clinics</li> </ul>	<b>Weaknesses</b>	<ul style="list-style-type: none"> <li>- Gaps in program coverage &amp; targeting</li> <li>- Mass &amp; interpersonal communications have been limited in reach, “stale”, and focus on brand promotion as opposed to safe behaviors</li> <li>- <i>New Start</i> services not consistently meeting quality standards and have limited reach</li> <li>- Insufficient use of research to inform programs, monitor field-level operations and evaluate impact</li> </ul>
<b>Opportunities</b>	<ul style="list-style-type: none"> <li>- Donor &amp; GRZ support for HIV/AIDS and malaria work</li> <li>- High levels of unmet consumer demand for injectables &amp; VCT</li> <li>- Market supports cost recovery products</li> <li>- Increasing access to anti-retroviral drugs increases consumer demand for VCT services</li> </ul>	<b>Threats</b>	<ul style="list-style-type: none"> <li>- Opposition (to condom promotion) from religious and other community-level groups limits HIV/AIDS prevention work</li> </ul>

<b>Strengthen Organizational Capacity</b>		<b>Indicators (by 2011)</b>
		1. External organizational assessments reflect improved capacity, systems & culture
<b>Objectives</b>	<b>Indicators</b>	<b>Activities</b>
<b>Build management and technical leadership</b>	1. Staff appraisals, program reviews, consultant reports and organizational assessments reflect improved capacity in managerial and technical skills. 2. Middle managers contribute to high-level program discussions. 3. SMT includes new Zambian program staff members by 2011.	1. Design & implement leadership program for middle managers (including opportunities to participate in high-level program discussions and skill development activities). 2. Recruit staff or utilize technical assistance to fill technical gaps including medical/service delivery issues, malaria expertise, MIS, research and new program areas as needed. 3. Formal & informal training linked to organizational priorities & individual performance objectives. 4. Cross-visit/s to other PSI programs w/ broad product and service portfolio, social franchise/s, and effective communications (e.g. PSI/Myanmar, PSI/Madagascar and OPL/Mumbai). 5. Expatriate Advisors and Zambian Managers transfer skills and management responsibility to national staff in key areas: program areas, financial management, accounting, MIS, communications & research; and are evaluated accordingly. 6. Develop and update “capacity building” position paper articulating: SFH capacity gaps, the role of external assistance and plan for the future. 7. Review & articulate role of SFH Board and Trust status; update as necessary.
<b>Streamline organizational structures &amp; systems for improved efficiency</b>	1. SFH receives annual average of 95% on PSI global financial scores. 2. SFH scores at least 90% on annual Overseas Financial Operations Group audits. 3. Average time between procurement request and final delivery decreases by 50%. 4. Increased use of MIS and research data for decision-making.	1. Develop fully automated financial system to monitor costs by platform, brand, etc. 2. Strengthen MIS function: incorporate key research findings, monthly sales and communications data into user-friendly interfaces accessible to program managers. 3. Streamline procurement procedures: halve number of steps in procurement cycle; increase outsourcing and blanket orders; implement Business Vision, etc. 4. Streamline and speed up approval and accounting procedures to facilitate the provision of funds to the field.
<b>Create and sustain vibrant internal organizational culture</b>	1. Program Managers spend at least 5 days per quarter outside HQ at program intervention level. 2. Each office visited >2 times/year by member of SMT, RM or Brand Manager. 3. Staff surveys reflect improving communication, morale & perceptions of opportunity.	1. Increase face to face communication between senior and middle managers and between HQ and field. 2. Repeatedly discuss mission, vision, values, beliefs and policies with all staff. 3. Institutionalize anonymous staff surveys: conduct, analyze & disseminate results annually. 4. Hold periodic retreats (programmatic & departmental). 5. Improve HQ office space and increase # of vehicles. 6. Encourage Managers to organize low-cost morale building activities (e.g. football, happy hours etc.) on a regular basis.

<b>Maintain positive external relationships</b>	<ol style="list-style-type: none"> <li>1. Stakeholder surveys indicate SFH continues to be viewed positively by partners.</li> <li>2. SFH presents at NAC &amp; NMCC Technical Working Group/s, donor meetings or other coordinating bodies at least 4 times a year.</li> <li>3. SMT and middle managers meet informally with at least 1 current or potential donor or GRZ contact (at national level) per month.</li> </ol>	<ol style="list-style-type: none"> <li>1. Aggressive advocacy: disseminate research findings &amp; related program experiences (including challenges) to donors, UN agencies, GRZ &amp; NGOs.</li> <li>2. Active participation in NAC &amp; NMCC Technical Working Groups.</li> <li>3. Continuously liaise with DHMTs in every district.</li> <li>4. Continue to cultivate partnerships with other NGOs to do work outside of SFH core competencies.</li> <li>5. Continue to respond to donors requests and submit high-quality reports (see Financial Viability activities).</li> <li>6. Encourage Zambian managers to interface with key GRZ and donor counterparts.</li> </ol>	
<b>Builds on / Takes advantage of:</b>		<b>Addresses:</b>	
<b>Strengths</b>	<ul style="list-style-type: none"> <li>- Positive reputation among GRZ, donor &amp; NGO partners</li> </ul>	<b>Weaknesses</b>	<ul style="list-style-type: none"> <li>- Slow, inefficient internal systems</li> <li>- Staff morale &amp; work ethic</li> <li>- Skill gaps (medical/service delivery expertise, communications &amp; research)</li> </ul>
<b>Opportunities</b>	<ul style="list-style-type: none"> <li>- Donor &amp; GRZ support for HIV/AIDS and malaria work</li> </ul>	<b>Threats</b>	<ul style="list-style-type: none"> <li>- Relationship with the Government deteriorates</li> <li>- Widespread distribution of condoms &amp; nets limits SFH effectiveness</li> </ul>

<b>Improve Financial Viability</b>		<b>Indicators (by 2011)</b>
		1. Annual program value of \$15 million (budget + in-kind contributions). 2. Cost recovery rate sustained above 5%. 3. Consistent annual reduction in key unit costs (e.g. cost per unit sold vs. CYP & DALYs)
<b>Objectives</b>	<b>Indicators</b>	<b>Activities</b>
<b>Increase and diversify donor support</b>	1. Annual budget for HIV/AIDS programming of at least \$6m. 2. Annual operating budget of at least \$1.2m for malaria. 3. Annual commodity support for ITNs to meet ITN sales targets. 4. Annual budget of at least \$1.5m for CDD. 5. Annual budget of at least \$1m for RH (excluding <i>SafePlan</i> commodities.) 6. At least 4 concept notes and 2 proposals submitted to potential donors per year.	1. Participate fully in multilateral funding initiatives (e.g. GFATM, UN agencies.) 2. Aggressively pursue funding agreements with: USAID, DFID, KfW, UNFPA. 3. Aggressively pursue funding agreements with GRZ. 4. Aggressively pursue foundation funding. 5. Document program effectiveness (see activities listed under Health Impact Matrix.) 6. Proactive and aggressive advocacy initiatives to increase SFH profile and contribution to health and development. (see activities described under organizational capacity matrix.)
<b>Maximize program income without jeopardizing focus on serving low-income communities</b>	1. Program income increases by 20% each year. 2. At least 3 products with COGS fully covered by program income by 2011. 3. Enterprise Funds contribute to 2% of annual recurrent costs by 2011.	1. Increase SFH product prices where appropriate while maintaining affordability. 2. Develop and market products/brands with full recovery of cost of goods sold (COGS.)
<b>Cut recurrent costs</b>	1. Recurrent costs (labor and ODCs) decrease to below 30% of total annual SFH expenditure. 2. All departments and platforms operate within annual budgets each year.	1. Reduce recurrent costs, including cutting and maintaining fringe rate from 78% to no more than 50%. 2. SMT assumes full responsibility for cost management. 3. Enhance monitoring & analysis of costs (e.g. expenditure by platform vs. output as measured by DALYs produced, expenditure by department vs. budget, net costs/unit sold, % cost recovery, and additional analysis of costs – i.e. cost per MVU show.) 4. Improve supply chain management, focusing on procurement, accounts, inventory management and warehousing functions, to maximize efficiency.
<b>Builds on / Takes advantage of:</b>		<b>Addresses:</b>

<b>Strengths</b>	<ul style="list-style-type: none"> <li>- Positive reputation among GRZ, donor &amp; NGO partners</li> <li>- Social marketing expertise: only group applying commercial marketing techniques to health in Zambia</li> <li>- Links to international PSI network</li> </ul>	<b>Weaknesses</b>	<ul style="list-style-type: none"> <li>- Funding gaps</li> <li>- High recurrent costs</li> </ul>
<b>Opportunities</b>	<ul style="list-style-type: none"> <li>- Donor &amp; GRZ support for HIV/AIDS and malaria work</li> <li>- High levels of unmet consumer demand for injectable contraceptives &amp; VCT</li> <li>- Market supports cost recovery/enterprise fund products (e.g. contraceptives)</li> <li>- GRZ becomes potential donor as a result of basket funding, SWAP, etc.</li> </ul>	<b>Threats</b>	<ul style="list-style-type: none"> <li>- Insufficient funding to sustain SFH's planned growth</li> <li>- Further appreciation of the Kwacha, inflation and high transportation costs limit programming</li> <li>- U.S. funding restrictions on HIV prevention programming increase</li> </ul>