



**SUCCESS  
RETURN TO LIFE**

**SEMI-ANNUAL PROGRESS REPORT  
Period: October 1, 2008 – March 31, 2009**

**Submitted by**

**SUCCESS Return to Life  
Catholic Relief Services-Zambia**

**To  
USAID/Zambia**

---

---

**May 15, 2009**

## Table of Contents

I. Acronyms .....	3
II. Executive Summary .....	5
III. Introduction .....	6
o SUCCESS Return to Life partners .....	6
IV. Strategic Objective 1:	
IR 1.1 .....	8
o Output 1: Standardized home based care visits .....	8
o Output 2: Increased Psychosocial support .....	11
o Output 3: Increased community Counseling and Testing.....	12
o Output 4: Increased Nutritional support .....	14
o Output 5: ART Adherence support is improved .....	18
o Output 6: Pain management services are improved .....	19
IR 1.2 .....	20
IR 1.3 .....	21
V. Strategic Objective 2:	
IR 2.1 .....	22
o Output 1: Improved standard of M&E reporting .....	22
o Output 2: Increased partner project management capacity .....	23
o Output 3: Increased technical capacity .....	24
o Output 4: Increased fundraising capacity for partners .....	24
IR 2.2 .....	24
o Output 1: Positive living groups are established and strengthened .....	24
o Output 2: PLWHA represented in decision-making bodies .....	24
IR 2.3 Creation of committed and supported volunteer force as caregivers .....	25
o Output 1: Caregivers linked to small business training .....	25
o Output 2: Trainings conducted for caregivers .....	26
o Output 3: Psychosocial support available for caregivers .....	26
VI. SUCCESS RTL Cross-cutting Activities.....	26
VII. Next steps .....	31
VIII. Appendices:	
Appendix 1: Success story, April 2009 .....	32
Appendix II: Food by Prescription Rapid Assessment .....	34
Appendix III: Food by Prescription Baseline Assessment .....	36
Appendix IV: Organizational chart for CRS-Zambia, SUCCESS Return to Life .....	38

## Acronyms

APCA	African Palliative Care Association
ART	Anti-Retroviral Therapy
ARVs	Anti-Retroviral Drugs
BMI	Body Mass Index
CDC	Centers for Disease Control and Prevention
CDH	Cancer Disease Hospital
CHAZ	Christian Health Association of Zambia
CIRDZ	Centre for Infectious Disease Research in Zambia
COP	Country Operating Plan
COP	Chief of Party
CRS	Catholic Relief Services
CTOR	Cognizance Technical Officer
DBS	Dry Blood Spot
DDA	Dangerous Drugs of Addiction
DEC	Drug Enforcement Commission
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
FANTA	Food and Nutrition Technical Assistance
FBP	Food By Prescription
GBP	Great Britain Pounds
GRZ	Government of the Republic of Zambia
HBC	Home Based Care
HEPS	High Energy Protein Supplement
HIV	Human Immune-deficiency Virus
AIDS	Acquired Immune Deficiency virus
IGA	Income Generating Activities
IR	Intermediate Result
IYCN	Infant and Young Child Nutrition
JHU	Johns Hopkins University
JHSPH	Johns Hopkins School of Public Health
M & E	Monitoring and Evaluation
MOH	Ministry of Health
MOU	Memorandum of Understanding
MT	Metric Tones
MUAC	Mid Upper Arm Circumference
NAC	National AIDS Council
NFNC	National Food and Nutrition Commission
OVC	Orphans and Vulnerable Children
PCAZ	Palliative Care Association of Zambia
PCV	Peace Corps Volunteer
PEPFAR	Presidents Emergency Plan for AIDS Relief
PLHIV	Persons Living with HIV
PRA	Pharmaceutical Regulatory Authority
RTL	Return to Life
RUTF	Ready to Use Therapeutic Food

SILC	Savings and Internal Lending Communities
SO	Strategic Objective
SO9	Strategic Objective Nine
STI	Sexually Transmitted Infections
STOC	Small Test of Change
SUCCESS	Scaling Up Community Care to Enhance Social Safety-nets
TAZARA	Tanzania Zambia Railway
TB	Tuberculosis
TF-CBT	Trauma Focused Cognitive Behavioral Therapy
USAID	United States Agency for International Development
UTH	University Teaching Hospital
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
ZESCO	Zambia Electricity Supply Company
ZPCT	Zambia Prevention Care and Treatment

## **Executive Summary**

CRS has implemented the SUCCESS Return to Life grant since July 2006 as a follow-on to a previous grant called SUCCESS. The grant is funded in three PEPFAR activity areas: Basic Care and Support, Counseling and Testing, and Anti-Retroviral Therapy Services (Adherence). The grant, which continued implementation through on-going partnership with six Dioceses, a stand-alone HBC program and eleven hospice partners, has a current life-of-project beneficiary target of 47,000 persons living with HIV ever receiving palliative care and support. The program utilizes a two pronged approach to care combining both Hospice and Home based care methods of programming in line with national care and support guidelines. Partners use a holistic care model that involves physical, psychosocial, and spiritual care aspects and enlists the involvement of the client, family members, caregivers and the wider community.

With an over-all goal of improving the quality of life of PLHIV in Zambia, SUCCESS has continuously demonstrated progress towards scale-up of palliative care. In the reporting period, SUCCESS Return to Life is on track to meet targets according to the President's Emergency Plan for AIDS Relief (PEPFAR) Country Operational Plan FY08. Since 2006, a cumulative number of 43,107 clients have been reached with care and support, with 32,602 receiving care in the last six months. In the reporting period, 4,911 new clients received palliative care, indicating that the program will achieve the COP08 target of 38,320 clients receiving palliative care.

Over the years, SUCCESS program has worked to implement innovative approaches to care and support appropriate for the palliative care needs of Zambia and in line with the World Health Organization (WHO) definition of palliative care "from diagnosis to end of life". During the previous six months, SUCCESS scaled up therapeutic nutrition provision activities reaching 977 severely and 1,051 moderately malnourished clients respectively. 1,322 persons received training from SUCCESS and their partners on palliative care topics that included adherence counseling, pain management, men as caregivers, and HIV and nutrition. With regard to pain management, all partners (100%) have level I drugs while 66% and 78% of hospices have level II and level III drugs respectively. Through PCAZ, the morphine fact book has been printed and is ready for launch and eventual distribution to partners and key staff. In an effort to advance palliative care concepts and to implement innovations, SUCCESS has introduced the pilot on Trauma Focused Behavioral Therapy (TF-CBT) working together with Johns Hopkins University. Partners continued to collaborate with their respective District Health Management Teams (DHMT) on VCT service provision and ART linkages.

In the next six months, SUCCESS RTL will continue palliative care service provision and will work to complete the planned activities for this year as per the approved work plan. Specific areas of focus in the remaining period include continued palliative care provision, pilot of Trauma Focused Cognitive Behavioral Therapy methodology, implementation of partners' sustainability plans, client verification, the end of project evaluation, and project close out activities.

## **Introduction**

SUCCESS Return to Life, a PEPFAR-funded palliative care grant, aims to improve quality of care and support for people living with or affected by HIV and AIDS. This goal has two interlocking strategic objectives inspired by the overarching theme of “Return to Life”. The supporting interventions are designed to improve quality of life as well as to extend it

Strategic Objective 1: Increased quality of comprehensive palliative care delivery by CRS partner HBC programs and hospices

Strategic Objective 2: Demonstrated progress towards sustainability of palliative care programs

This phase of the grant began on September 30, 2008, with an extension through December 31, 2009. Activities reported in this document highlight six months of progressive project implementation, which continued uninterrupted throughout the start of the extension phase. The main focus of the fifteen-month extension is implementation of sustainability measures for effective continuum of quality palliative care beyond the grant period.

The grant continues to serve as a key contributor to the United States Agency for International Development (USAID) - Zambia’s Strategic Objective 9: Reduced HIV/AIDS Impact through a Multi-sectoral Response. In addition, the program contributes to the Government of Zambia (GRZ) National HIV and AIDS Strategic Framework, through Theme II, “Expanding Treatment, Care and Support”.

## **SUCCESS Return to Life partners**

CRS as an organization does not provide direct service provision to beneficiaries, but rather builds capacities of indigenous partners to manage, support, and expand initiatives within their organizations and communities. During the extension, SUCCESS RTL did not add any new partners, and continued to support the twenty local implementing partners carried over from the previous grant period. Partners provide palliative care in all nine provinces of Zambia, although not in all districts. The number of service outlets providing HIV-related palliative care (including TB/HIV) increased to 104 in this period. One of the sites under Solwezi diocese (Ntambu) was divided into two separate sites namely Ntambu (St. Andrew Kim) HBC and St. Philips HBC.

CRS provides block grant funding as well as technical support and training to eleven **Hospices**, which include stand alone (private) facilities or those based at a mission hospital. The hospices working under SUCCESS RTL program are both faith-based and non faith-based organizations. All hospices are managed through a board and have a well-organized staffing structure with management, administration and finance staff as well as technical staff that discharge duties in a coordinated, well-organized professional manner. Services are provided free to the public. Block grant funds from CRS allow hospices to purchase necessary equipment and supplies for their inpatient programs, and also support outreach and training activities. An additional hospice, Missionaries of Charity in Kabwe, does not receive funding or technical support from CRS, but received a vehicle during a previous phase of the project which they continue to use as part of palliative care services.

CRS provides funding and technical support to home based care partners covering five provinces and one urban center, namely **six Catholic Diocese partners and one stand-alone home based care partner in Livingstone**. Established under the Episcopal Conference of Zambia, dioceses are regional institutions that have a faith and development agenda. Headed by a Bishop, each diocese runs its own development program that is managed through a clearly defined system with strategic business units relevant to the type of development programs they have. There is a Development (Caritas) Director who heads the diocesan development program through which all development and health departmental heads report. The Bishop is the custodian of all diocesan resources and programs and in all cases, each diocese has a board which helps the bishop with executive advisory roles. Each diocese is independent of the other and has the mandate to raise resources through various means for program work. The Zambia Episcopal Conference has a coordinating role for all diocesan activities in the country through the National Caritas office. Most if not all Dioceses working under SUCCESS RTL have provided palliative care services pre-dating PEPFAR support, and have strong community health volunteer and health professional resource bases. Dioceses offer services to all community members irrespective of their religious affiliation. Funding from CRS PEPFAR funds supports Diocese home based care staffing, community mobilization, palliative care training and education, and other related activities.

SUCCESS RTL continues to support the **Palliative Care Association of Zambia (PCAZ)** to ensure advocacy for palliative care policy, essential drug availability, training and the provision of palliative care services in Zambia for all those with life-threatening illnesses. African Palliative Care Association (APCA) co-supports this national body, although due to a funding shortage at APCA during the SUCCESS extension, CRS now supports a larger percentage of PCAZ operations than in previous years. PCAZ has been successful in advocating with the Ministry of Health (MOH) and other GRZ authorities for the provision of oral morphine in hospices to ensure quality pain management of clients. In late 2008, the Ministry of Health signed a formal Memorandum of Understanding with PCAZ recognizing the organization’s role as the lead agency for palliative care in Zambia and agreeing on the relationship between the two national-level bodies.

Table 1 below shows the SUCCESS implementing partners by type and location.

**Table 1**

	<b>Partner name</b>	<b>Type</b>	<b>Province</b>	<b>Number of Parishes or service outlets</b>
1	Lumezi	Hospice	Eastern	1
2	Minga	Hospice	Eastern	1
3	Our Lady’s Hospice	Hospice	Lusaka	1
4	Mpanshya	Hospice	Lusaka	1
5	Jon Hospice	Hospice	Lusaka	1
6	Human Service Trust	Hospice	Lusaka	1
7	Mother of Mercy	Hospice	Lusaka	1
8	Ranchod	Hospice	Central	1
9	Cicetekelo	Hospice	Copperbelt	1
10	Martin	Hospice	Southern	1

11	St. Joseph's	Hospice	Southern	1
12	Missionaries of Charity	Hospice	Central	1
13	St. Francis Home Based Care	HBC	Southern	1
14	Mansa Diocese	HBC	Luapula	10
15	Kasama ArchDiocese	HBC	Northern	16
16	Mpika Diocese	HBC	Northern	17
17	Solwezi Diocese	HBC	Northwestern	18
18	Mongu Diocese	HBC	Western	15
19	Chipata Diocese	HBC	Eastern	15
20	PCAZ	National coordinating body	Lusaka	n/a

### **Strategic Objective 1:**

***Implementation progress: September 30, 2008- March 31, 2009***

The SUCCESS Return to Life Strategic Objective 1 is “increased quality of comprehensive palliative care delivery by CRS partner HBC programs and hospices”. Under this SO are three intermediate results:

- **IR 1.1** Existing services within HBC programs and/or hospices are strengthened
- **IR 1.2** Increased involvement of youth and family members, including men, in providing care for PLHIV.
- **IR 1.3** Increased service linkages with other provider organizations and programs.

Progress toward each intermediate result over the last six months is detailed in the sections below.

#### **IR 1.1 Existing services within HBC programs and/or hospices are strengthened**

##### ***Output 1: Standardized home based care visits***

SUCCESS Return to Life partners continued to provide home based care visits in the last six months. Each Diocese HBC program implements home-based care through their network of parishes, each of which is further divided into sub-areas with cadres of community volunteers. Each parish is overseen by a Site Coordinator who coordinates community care within existing networks. Hospice programs either run their own outreach palliative care services, such as Mpanshya, or link with other home-based care programs, such as the Our Lady's Hospice linkage with ArchDiocese of Lusaka Home Based Care (funded by RAPIDS).

Partner programs provided HIV and AIDS related palliative care to 4,911 new clients during this reporting period. This increased the total number of clients who ever received palliative care to 43,107. SUCCESS – RTL program is in a good position to meet the life of project target of 47,000 clients ever receiving care by December 2009. The number of palliative care clients reached within the reporting period of September through March 2009 is 32,602 which is on

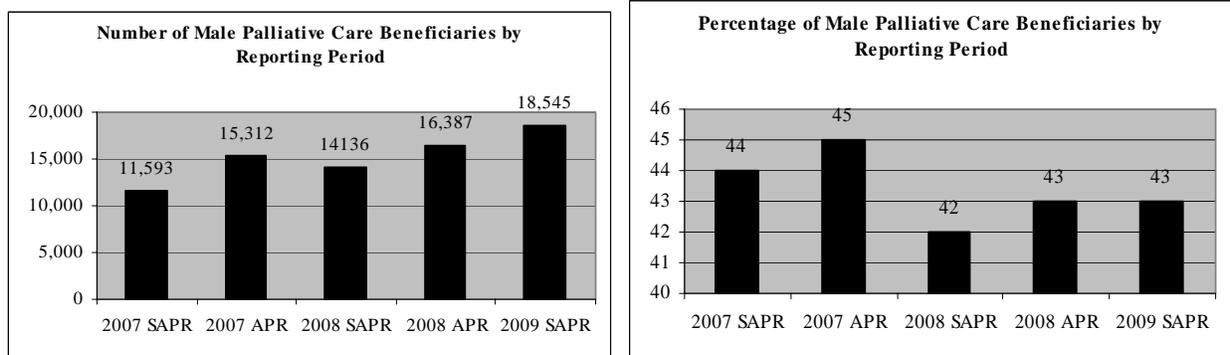
track to meet the COP08 target of at least 38,320 clients. Of the 10,505 patients not currently active, the majority are those who were discharged from inpatient hospice care into an HBC program, so the hospice stopped counting them as patients. Other losses include death, persons completing TB treatment and discharged from HBC, as well as some palliative care clients who were lost to follow up.

HBC sites greatly outnumber hospice sites, (87% and 13% of SUCCESS sites respectively), but the hospices reported 51% of the new clients while Diocese Home Based care partners reported 49% new clients. This could be attributed to the models of care where hospices are first point of contact for palliative care clients while home based care programs heavily rely on referrals from DHMT, Mission and other health facilities. It could also relate to the higher turnover of inpatient clients in the hospice setting compared to the Dioceses. Finally, it could also relate to the geographic expansion of hospice outreach programs due to increases in CRS or other funding.

SUCCESS partners continue to provide palliative care to infants, children, and adolescents. Hospices have a combined total of 27 beds reserved specifically for inpatient pediatric palliative care. SUCCESS up to this point has not reported on numbers of pediatric clients on palliative care. The figures of palliative care clients were always reported as block figures with the only disaggregation being by gender. From February and March 2009 a new monthly statistical M&E form was rolled out and this capture information on pediatric palliative care clients. By April 2009 all partners will be reporting this information. With this the program will be better able to keep track of the numbers of pediatric palliative care clients.

In terms of the gender disaggregation, the percentage of male and female clients reached with HIV and AIDS related care and support as at March 31<sup>st</sup> 2009 was 43% and 57% respectively i.e. 18,545 male and 24,562 female clients.

**Figures 1 & 2: Male palliative care beneficiaries over time**



Although the percent of male clients has not increased, the numbers are increasing at the same rate as females. However SUCCESS partners have made recent investments in activities for increasing men as caregivers and beneficiaries in palliative care. We hope to see promising results in the next reporting period. These initiatives are described in IR 1.2 below.

In the last six months, all partners have received a monitoring and support visit by CRS palliative care project officers. During these visits, CRS uses a partnership model to dialogue with partners regarding updates on activity implementation. Of late, CRS is starting to build capacity of partners to use data for programmatic decision making, such as with the introduction of the small test of change concept. SUCCESS paid particular attention to discussion on specific technical areas of the grant extension, including linkages between VCT-ART-palliative care programs, pain management, pediatric palliative care, and caregiver management. Partners are using the three palliative care packages to tailor services to client needs, targeting HIV+ asymptomatic clients, HIV symptomatic clients, and HIV end-of-life clients. All partners have the HBC minimum standards booklet, and CRS and PCAZ are working together to ensure partners understand and use the manual. Visits to inpatient Hospice facilities focused more intensely on supporting staff on aspects of palliation ranging from client diagnosis, assessments and counseling. The project is in the process of laying ground for piloting of patient held records for standardized visits; however, all home visits are recorded in the client visitor's book and health visiting caregiver activities can be traced in the visitor's book at the client's home as per the national standard guidelines

In COP08, CRS, PCAZ, and partners target to train 2000 health professionals and caregivers in palliative care, including HIV and nutrition, palliative care and pain management, adherence counseling, positive prevention, PMTCT referral, and other technical areas. As of March 31, SUCCESS supported new and refresher training of 1,322 persons. Major central trainings conducted by PCAZ include Men as Caregivers held in January and the Palliative Care Training of Trainers held in February. CRS facilitated an Adherence Training in Lusaka for all partners, as well as an HIV and Nutrition and an M&E training specifically for hospices. CRS staff also traveled to 4 of 6 Dioceses to conduct HIV and Nutrition training, and to all 6 Dioceses to conduct M&E training. Finally, CRS also held a sustainability workshop for all partners in Lusaka in January.

CRS anticipates that this ambitious training target from COP08 will be achieved. In the upcoming six months, partners will continue to cascade trainings to community level, PCAZ will train Dioceses on HBC Minimum Standards, and CRS will provide central trainings on Pediatric Psychosocial Counseling, Positive Prevention, and PMTCT referrals. The latter three trainings were planned in the last reporting period but were delayed in implementation for various reasons. Pediatric Psychosocial Counseling training was delayed three times due to lack of sufficient training of Ministry of Health facilitators; the MOH facilitator training was scheduled for late April with the actual training for SUCCESS scheduled to start on May 4<sup>th</sup>. SUCCESS dedicated the previous reporting period to designing a Positive Prevention curriculum for CRS that is appropriate for faith-based partners and provides evidence-based, factual information about HIV prevention approaches. This training is scheduled to begin on May 11. The PMTCT referrals training will be conducted by AIDSRelief facilitators, and the training date was postponed due to the facilitators' busy field visit schedules, but dates have been finalized and locked in for early June. Although these delays were unanticipated, they actually benefit our partners in that they

have more time following the previous trainings to cascade the information downwards through their caregiver networks.

### ***Output 2: Increased Psychosocial support***

CRS was very encouraged to see the adoption of the Pediatric Psychosocial Counseling curriculum by the Ministry of Health in late 2008. The development of this curriculum was an initiative of CRS and the African Network for Care of Children Affected by AIDS (ANECCA), which piloted the program in several African countries where the PEPFAR-funded AIDSRelief program is implemented. SUCCESS utilized this curriculum in the previous grant period, and the demand for continuation of this training is great in Zambia. One major challenge experienced in the last six months was the lack of a Training of Trainers program for the Pediatric Psychosocial Curriculum which would enable Ministry of Health and other highly trained child counselors in Zambia to implement training. This barrier will be eliminated in April 2009, thanks to a two-day TOT through Elizabeth Glaser Pediatric AIDS Foundation, but the challenge of how to roll-out trainings on a larger scale with limited numbers of facilitators still remains until a larger TOT program can be developed.

Despite the lack of frequent training opportunities, partners continue to conduct psychosocial support activities for children as part of palliative care. Most hospices have dedicated pediatric palliative care beds or rooms, where counseling is provided, and some hospices have Day Care facilities for children offering psychosocial activities. Hospices that provide outreach include service provision to pediatric clients. Home based care programs continue to run support groups for positive children and provide home visits to HIV+ or HIV-exposed children.

If psychosocial counseling needs are unmet, then any higher level of mental health services are certainly an even larger gap. Palliative care partners have shared that there is a great unmet need for trauma therapy services in their communities, but unfortunately due to a lack of monitoring or assessment tools, the extent of trauma occurring in the population is unmeasured. Based on a study in Zambia, major issues identified among women affected by HIV and AIDS and their children include domestic violence, depression-like syndrome and alcohol abuse and child defilement<sup>1</sup>. Based on the observational and qualitative information, SUCCESS felt that the need for trauma focused therapy is high in palliative care programs.

USAID linked CRS to Johns Hopkins University School of Public Health, and through discussion, both institutions planned a pilot program of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT is defined as a therapy that helps children, youth and their families who have been affected by traumatic events. Traumatic events include physical and sexual child abuse, rape or assault, exposure to domestic or community violence, serious accidents, natural or human disasters, violent crime, violent or sudden death, or any other experience that creates threat or fear. The child/youth may actually experience the event, witness the event or have a close loved one who experienced the event. TF-CBT involves psycho education, emotion regulation, correcting maladaptive beliefs, trauma narrative and positive parenting. TF-CBT is flexible and individualized to the needs of each child/youth and family.

---

<sup>1</sup> The lancet vol 370 Set 2007

TF-CBT will be an advanced follow-on to the AIDSRelief curriculum, and implemented as a next higher level of services. The addition of training in trauma assessment and TF-CBT skills will allow SUCCESS RTL partners to take counseling to a higher level when psychosocial care is not enough to meet the child's mental health needs. This methodology shall integrate into current partner services under the SUCCESS RTL project therefore shall add onto the value of the services to the clients currently being served. Assessment in the community is expected to have the added benefit of identifying new children in need of holistic palliative care services who are currently underserved. Adding TF-CBT to the existing package of palliative care is expected to increase quality of pediatric palliative care services, with a specific benefit of increasing access to therapy services for children who have experienced trauma.

Since January 2009, the pilot program has been carefully planned through distance communication between JHSPH and CRS, as well as through an on-site visit by a consultant in March 2009. University of Zambia School of Public Health and the Ministry of Health have also been closely involved in the planning of the pilot. Two urban SUCCESS RTL partners, Jon Hospice and Ranchod Hospice, were selected to participate in the pilot. CRS also linked with other community-based programs in Lusaka and Kabwe run through Kara Counseling (Hope House and Sables), as well as with another PEPFAR-funded program, PCI KIDSafe, who will also pilot this program in the upcoming six months. The Ministry of Health also requested that Kanyama Clinic be involved in the pilot. Assessment and therapist trainings are targeted to begin in May 2009, and the pilot will wrap up in September 2009 (although therapy and assessment will continue as part of partner programs after the end of the pilot).

### ***Output 3: Increased community Counseling and Testing***

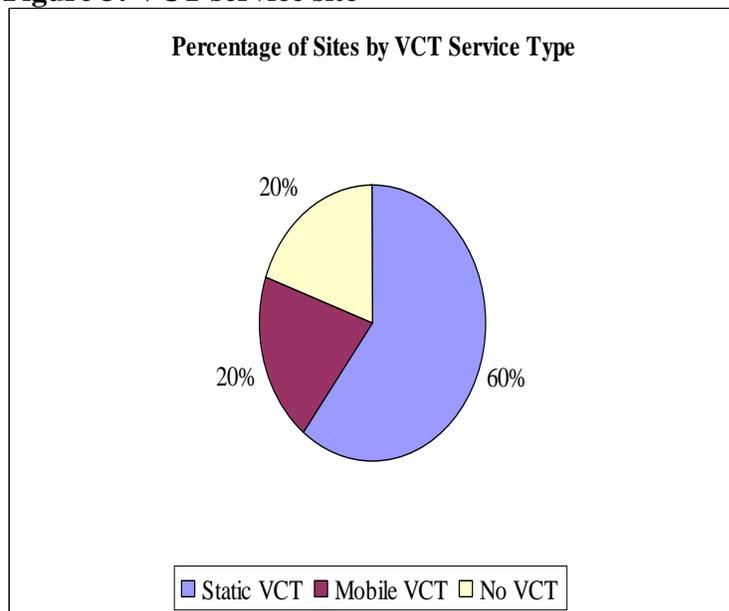
SUCCESS RTL partners continue to provide HIV counseling and testing services through static VCT centers and mobile clinics. In COP08, the VCT site target was 19 service locations. However, with finger prick testing, partners have been greatly able to expand services. Partners currently have 58 VCT sites providing the full set of counseling and testing services. Mobile VCT units operated by the partners provide counseling and testing services in 20 different sites un-reached by static VCT locations. One major milestone in the last six months was the establishment of a registered VCT center with seconded MOH staff at Human Service Trust Hospice, based on their growing relationship with Kafue DHMT.

Some partners have tried house-to-house testing with mixed results. In rural areas, the time and manpower required was not effective given the lower HIV positivity rates. In urban areas, where homes are nearer to one another and prevalence is high, house-to-house testing is more feasible but still continues to be time intensive. There are no major plans for partners to expand house-to-house testing this year, with exception of Martin Hospice, a program which has found house-to-house testing to be very successful. HBC programs have instead focused on using their M&E data to identify areas with low rates of men receiving VCT, and then taking mobile VCT to those places. Solwezi HBC used the chiefs and headmen as entry points into the remote community. They were able to test over 100 persons on the outreach day, and tested equal numbers of men and women, including many couples. However, only 2 persons tested positive, which again raises the question of time and resource effectiveness of reaching such a remote area. ArchDiocese of Kasama HBC had a similar experience as Solwezi Diocese, but plans to continue

taking mobile services to increasingly remote areas noting that demand for VCT is higher the further they travel from town centers signaling an unmet need.

The number of clients provided with counseling and testing services in the last six months was 14,994, comprising 8,981 female and 6,013 male clients. The program is on track to exceed the COP08 target of 20,500 clients. Compared with the 40,000 target for counseling and testing for the extension through December 2009, this figure represents a 37.5% achievement towards the target. The increase in the number of counselors has resulted in higher accessibility of counseling and testing services, and therefore resulted in higher testing numbers.

**Figure 3: VCT service site**



All partners provide finger-prick testing, with exception of St Joseph in Livingstone which has not yet been trained. Mpanshya Hospice reported that they identified highly competent volunteer caregivers from their community program last year for training in finger prick methodology, and have experienced no turnover of trained staff a year later. During the reporting period, HBC partners rolled out training in finger prick method of testing for HIV reaching 114 counselors between October 1<sup>st</sup> 2008 and March 31<sup>st</sup> 2009. This is below the VCT training target of 850 for COP08. Partners have training activities included in their work plans and will be cascading training in this area within their networks over the next six months.

In general, partners have established good working relationships with local DHMTs. Many HBC programs use local MOH personnel from rural health centers to carry out mobile VCT. Some HBC programs are making efforts to ensure that all VCT counselors are registered and that the correct MOH reporting forms are available. Because they are not fully working with the DHMT, the DHMT is not always able to provide the test kits that the HBC program requires. Mongu Diocese is an example of how collaboration with the MOH on VCT ideally should work, with the Diocese invited to MOH trainings on the new test kits logistics system and the Diocese reporting faithfully into the MOH system and receiving adequate numbers of test kits. Mongu Diocese has shared this success with other Diocese partners and given instruction on how the Dioceses can better collaborate with their respective DHMTs.

#### ***Output 4: Increased Nutritional support***

During the reporting period, SUCCESS RTL re-initiated the nutrition component, which uses Ready To Use Therapeutic Food (RUTF) for treating severe malnutrition and High Energy Protein Supplement (HEPS) for treating moderate malnutrition, supporting ten hospices namely, Mother of Mercy, Human Services Trust, Jon, Our Lady's, Martin, Ranchod, Mpanshya, Minga, Cicetekelo and Lumezi, Circle of Hope ART clinic, and St Daniel and Zambezi parishes in Solwezi diocese and St Anne Parish in Chipata Diocese. The program reached 977 severely and 1,051 moderately malnourished clients respectively.

During the same period, the program started the process of geographic scale-up by training additional Diocese partners. In addition, SUCCESS RTL initiated a pilot program in nine health facilities where treatment of clinically malnourished ART clients has been synchronized with ART services in partnership with AIDSRelief (St Francis, Chilonga, Wusakile and Siavonga hospitals and Chreso Ministries clinic); ZPCT (Ndola Central and Serenje hospitals); IYCN (Chelstone clinic) and CIRDZ (Our Lady's Hospice). Provision of RUTF and HEPS has not yet started in these scale-up sites due to delays in procurement processes.

For the period under review, major achievements were as follows:

##### **(a) Planning and Assessment for Food By Prescription (FBP):**

FBP implementation strategy and detailed implementation plan (DIP): SUCCESS RTL developed a FBP implementation strategy and a 13-month Detailed Implementation Plan (DIP). The DIP outlines the following thematic areas: community mobilization to promote understanding of the program objective and methods; Development of networks/linkage/referral systems; Linkages with other sectors and initiatives, Human resources; Local organization capacity development; Quality assurance and supportive supervision, Monitoring and Evaluation and reporting; Training and Commodity procurement. Activities have been detailed in line with these thematic areas.

FBP planning meetings with stakeholders: Meetings were held with AIDSRelief, ZPCT, CIRDZ and IYCN (PEPFAR partners providing ART services) to discuss the objective of the pilot and the need for the partnership. Each partner selected one or more sites where the FBP pilot program was to be implemented. FBP site selection depended on HIV services provided (ART and/or PMTCT), large ART client case, high estimated malnutrition rates and high HIV prevalence rates. One notable challenge encountered in the initiation of the FBP program was the delay by PEPFAR partners to identify sites for the FBP pilot. One of the four partners only managed to confirm sites in December 2008. Hence the rapid assessment that took place from November to December was conducted only in AIDSRelief sites. This delay also affected the plan for commodity procurement because there were no target estimates to base the plan on.

FBP rapid assessment: Before initiating the FBP project, a rapid assessment was conducted in four FBP sites (Siavonga, Chilonga and Wusakile hospitals and Chreso Ministries clinic) from November – December 2008. This was to understand:

- Food insecurity and nutritional needs of different groups of PLHIV,
- The prevalence of severe and moderate malnutrition among ART clients,

- The capacity of current community and hospital-based HIV programs to meet the nutritional needs of PLHIV,
- Human resources and institutional capacity to integrate and implement FBP program,
- Food products availability, production and distribution modalities and channels.

See **Appendix II** for a summary of the rapid assessment findings. Rapid assessment findings informed development of baseline survey tools.

FBP baseline survey: The baseline survey was conducted from January – February 2009 and the primary objective was to establish baseline measures to assess the nutritional impact of RUTF on severely and moderately malnourished ART clients using a hospital based approach. The secondary objective was to document the rehabilitation trajectory of severely and moderately malnourished ART clients using a combination of RUTF and HEPS. Three tools were used to provide triangulation for some variables especially the section on client screening and assessment practices/procedures by the health staff versus the exit interviews with clients. See **Appendix III** for baseline survey findings.

Nutrition communication strategy: To promote program awareness, information about therapeutic food supplements, and to change people attitudes, behaviors and practices as regards management of malnutrition, an external consultant has been engaged to develop a nutrition communication strategy. The aim is to improve communication efforts and ultimately achieve desired attitudes, behaviors, practices, policies, budgets, programs and projects. The outcome of the strategy will also inform the type of IEC materials to develop and their channels of communication. The outcome of this activity will be reported in the next reporting period.

Government collaboration: Early in FBP planning, a meeting was also held with the National Food and Nutrition Commission (NFNC) Acting Executive Director to introduce the program and solicit partnership. Thereafter a number of meetings were held with the NFNC Public Health section to discuss and validate the implementation strategy and their role in the pilot.

Although CRS closely collaborated with NFNC, some aspects of collaboration caused challenges to CRS in rolling out the program on the expected timeline. One major challenge faced by CRS was that it was extremely difficult to finalize FBP materials because the government frequently changed the selection and discharge criteria and food protocols in the FBP guidelines. At the time of reporting, these guidelines are still in draft form and need additional revision. Another challenge has been a delay by NFNC to obtain an authorization letter from MOH on behalf of CRS. This letter is required by government health facilities to show authorization by the MOH that they facility can participate in and receive commodities through the FBP program, as per government protocol and policy. Without this letter, some DHMT refused the baseline team to obtain certain information from their sites and the consultant developing the communication strategy could not interview government stakeholders unless they presented a letter from the MOH Permanent Secretary. CRS is following up with NFNC so that this letter is obtained and the Director for Public Health and Research in MOH is aware of this issue.

#### **(b) Nutrition Capacity building**

Trainings: Preliminary results from the baseline survey reported that although hospitals have adequately trained staff to identify malnutrition, the data showed that some of the important steps

in screening for malnutrition were not mentioned by the staff - an indication that they do not follow the screening steps to the book. Furthermore, key measurements such as BMI, MUAC and assessment for bi-lateral oedema are not routinely measured or understood by staff as being important or necessary.

SUCCESS RTL therefore organized a five-day FBP training from 2 – 5 February 2009 where 29 participants from all the nine FBP sites were trained. The workshop was facilitated by CRS, FANTA, NFNC and Wusakile Hospital. Topics included: Overview of FBP; Link between HIV and Nutrition; Nutrition assessments, Counseling and Education; Management of Severe Acute Malnutrition without complications (Outpatient care); Management of Severe Acute Malnutrition with complications (Inpatient care); Management of Moderate Acute Malnutrition (Supplementary feeding); Food commodities and protocols for FBP; Commodity management and logistics; Monitoring and Evaluation and Integrating FBP in ART services. Each site developed an action plan on the roll out of trainings. As of March 31, all FBP pilot sites had held a number of orientation meetings and trainings for health staff, adherence supporters and volunteers where such groups exist.

From January to March 2009, SUCCESS RTL conducted an additional four nutrition workshops in Mansa, Mpika, Chipata, and Kasama Dioceses and one refresher training in Lusaka for hospice partners. A total number of 104 site coordinators and caregivers from dioceses were trained and 21 health staff were trained from the hospices. Topics covered included:

- Definitions of terms and concepts in management of malnutrition;
- Malnutrition and HIV,
- Malnutrition in adults, adolescents and children
- Anthropometric measurements
- Selection and discharge criteria for severe and moderate malnutrition
- Managing clinical malnutrition in children, adolescents and adults
- Food protocols for severe and moderate malnutrition
- Documentation
- Monitoring and reporting tools (program and logistics)

SUCCESS RTL also intended to review the HIV and Nutrition training manual developed by CRS headquarters in collaboration with government. This was not achieved because NFNC at the same time was in the process of developing the national HIV and Nutrition training manual. The national manual has not been finalized yet. NFNC has agreed to incorporate components from the CRS manual that are missing in the national manual so that there is only consolidated document at national level.

Quality assurance: During the reporting period, SUCCESS RTL developed a training manual that was used for all the trainings conducted. This document details basic topics on management of clinical malnutrition as outlined in national FBP guidelines and integrated management of acute malnutrition guidelines. This was necessitated by the wide range of capacity of our implementing partners as well as demand for standardized information. SUCCESS RTL envisions that by the end of this fiscal year, all the three models (diocese, hospice and health facility) of service delivery will have a standardized FBP approach, hence the development of the draft manual.

Other materials developed include program minimum standards of care (adapted from SPHERE standards); development and dissemination of job aids (screening cards, food protocols, charts for selection and discharge) and adaptation of the FANTA FBP flowchart. A number of tools were also developed and printed, including patient and beneficiary dispensing registers, patient cards, prescription forms and monthly report forms.

Field visits: During the reporting period, several field monitoring visits were conducted to ensure quality services delivery. Such visits included (i) Follow-up of trained personnel to determine how knowledge and skills acquired was being utilised, and also to follow up on the action plans developed during the trainings. (ii) Supportive visits conducted to hospices and Dioceses to determine how recruiting and discharging severely and moderately malnourished clients is done, program documentation, how and when to report, commodity forecasting and commodity management. This has resulted in improved program implementation overall. (iii) Technical visits were conducted to FBP sites to discuss in-depth how to fill in information in the patient register, commodity register, patient card, prescription form and the monthly report form. All sites visited had started recruiting clients and were eagerly waiting to start the program.

FBP program indicators: In addition to existing nutrition indicators that are being tracked for the Diocese and hospice program, FBP input, process/output and outcome program indicators have also been developed to provide greater detail as well as to measure the quality of service provision. These indicators are subject to modification as activities progress and experience is gained in these areas.

Database: A database has been developed for the FBP program. This will enable systematic data collection and reporting by all sites. Since the FBP program is still at pilot phase, this database will be managed centrally at CRS. Future plans are to incorporate information from dioceses and hospices as well.

### **(c) Nutrition program procurements**

CRS commodity and logistics unit in collaboration with SUCCESS RTL program staff developed quarterly food forecast and distribution plans for Diocese and hospice partners. In the reporting period, 78 Metric Tons (MT) of HEPS costing a total amount of \$54,600 and 60.68 MT of RUTF costing a total of amount of \$351,944 were procured for ten hospices, Circle of Hope, and two HBC partners, reaching a total of 977 severely and 1,051 moderately malnourished clients respectively.

In the past reporting period, RUTF was procured from VALID International and HEPS was procured from SEBA Foods Limited. Rigorous quality analysis was done for every batch of food bought. Microbiological and biochemical tests were carried out to ascertain the quality and to ensure this is in line with the national food and drugs standards as well as the recommended standards of the Codex Alimentarius. Institutionalizing quality assurance for these foods has ensured only high quality products are provided to clients. In cases in which the food did not meet standards, the companies were obligated to replace those batches, which caused delays. CRS also found that the analysis takes longer than anticipated, sometimes lasting one month, due to capacity issues at accredited government laboratories. In future orders, CRS will place this testing responsibility solely as responsibility of suppliers (after the initial testing during the competitive bidding process) to avoid delays and return to responsibility on those producing food and the national regulatory bodies in Zambia.

CRS is in the process of procuring 108 MT of HEPS and 100 MT of RUTF costing approximately \$580,000 and \$79,000 respectively. CRS estimates that this amount will cater for remainder of 2009 for FBP, Diocese and hospice sites. CRS commodity and logistics unit is responsible for procurement of supplies and commodities and since November 2008 when the HEPS process started, and they have not finalized this procurement. As of March 2009, competitive bidding was completed for HEPS, a local supplier was identified, necessary approvals were granted, and contracts were prepared. The SUCCESS program is now anxiously waiting the imminent distribution of HEPS to our partners. In the meantime, SUCCESS RTL is discussing with AIDSRelief procurement team to assist with the commodities supply chain process to AIDSRelief sites. Discussions will also resume with Medical Stores Limited so that they can deliver the commodity to government FBP on behalf of SUCCESS RTL, as the packaging of the commodity is now in conformity with their standards. In the meantime, CRS will contract local trucking companies to deliver the food products to these sites.

Other procurement activities included printing 200 patient registers, 500 food registers, 15,000 patient cards, 15,000 beneficiary monthly report forms and 500 prescription forms costing approximately \$600. SUCCESS RTL also procured off-shore medical supplies costing \$5,883: 20 adult scales, 20 Salter scales, 20 calculators, 20 height measures and 200 MUAC tapes.

Planned nutrition activities for next reporting period:

- Distribute food commodities (RUTF, HEPS, and Chlorin)
- Conduct monthly supervisory visits to all sites to assist data collection. From the rapid assessment and baseline findings, FBP sites are already overwhelmed with reporting and therefore, if reporting is left to each site, reports may delay and will defeat the objective of the pilot.
- Finalize the electronic database. Data from hospices and dioceses will also be incorporated.
- Finalize Communication strategy and develop IEC materials as well.
- Finalize contracts between CRS and CHAZ and between CRS and Medical Stores Limited to enable delivery of commodities to FBP sites.
- Hold a central review meeting with FBP sites to review progress made so far.
- Conduct end FBP program evaluation.

***Output 5: ART Adherence support is improved***

SUCCESS RTL has continued offering adherence support to clients on ART as part of palliative care, with the goal of maintaining a low ART defaulter rate and consistency in usage of ART drugs, thereby minimizing chances of resistance and other complications. In this regard, caregivers have been trained and supported to ensure 95% or greater adherence to ART among palliative care clients. The project recognises family members as primary or immediate caregivers and has worked with them to ensure that clients are consistent in taking their medication. It also teaches them to recognise signs of opportunistic infections, a sign of resistance on those on ARVs, to seek treatment and counselling in local health facilities.

Linkages to ART clinics for medication pick-ups and laboratory tests are facilitated with the help of project “adherence vehicles” given to partners. The number of clients who received ART adherence support during this period was 23,450 comprised of 8,560 male and 14,890 female

clients. This implies that about 63% of clients receiving adherence support were female clients and only 37% were male clients. However, SUCCESS believes that this number is greatly undercounted by our partners. In the next six months, all partners will be implementing the new M&E reporting requirements for the grant, which will provide more accurate data on adherence support to palliative care clients.

ART adherence counseling is integrated into all palliative care services at the 104 outlets reached by SUCCESS partners. In March, CRS trained twenty-two participants from partner programs in adherence support. The five-day training focused on understanding the importance of adherence and the dangers of resistance, and built capacity of participants to conduct adherence counselling. Through cascading of trainings in HBC networks and hospice programs, a total of 462 caregivers were also trained in adherence.

### ***Output 6: Pain management services are improved***

SUCCESS continues to support partner efforts to increase palliative care clients' access to appropriate pain relief. After concerted advocacy efforts, the Ministry of Health released an authorization letter in October 2008 permitting oral morphine to be prescribed and dispensed by Hospices. While the letter is the key step that was missing in the past, the ability for hospices to acquire reconstituted oral morphine still remains a challenge. Supply chain systems are not in place to move morphine powder to reconstitution at UTH and down to the hospices, and many hospice staff still are not comfortable using this level of pain medication.

Over the last six months since the release of the MOH letter, PCAZ has spearheaded the planning for morphine roll out to the Hospices. PCAZ, together with a panel of stakeholders, successfully re-submitted a proposal on the morphine strategy in Zambia to The True Colors Trust (UK), which has ring-fenced GBP 200,000 for a two year pilot. CRS was heavily involved in supporting PCAZ in proposal development and review, sitting on panel discussions, and providing True Colors with supporting documents and information. SUCCESS RTL staff participated in two visits to Zambia from True Colors Trust representatives.

PCAZ continues to strengthen their national network of stakeholders in pain management advocacy, working closely and holding regular meetings with the Ministry of Health (MoH) Director Clinical Care and Diagnostic Services, Chief Pharmacists at University Teaching Hospital and MoH, and the hospices. An advocacy team from APCA visited key policy personnel in the Ministry of Health, Drug Enforcement Commission, and Pharmaceutical Regulatory Authority (PRA) with the objective of enhancing their understanding of the benefits of oral morphine in palliative care.

SUCCESS continued to mentor partners in pain management using the WHO Analgesic ladder, and observes universal assessment of pain by both Hospice and HBC caregivers. Partners at HBC facilities are accessing mainly Level 1 drugs and adjuvants, with Paracetamol, Ibuprofen and Diclofenac readily available at most centers. Availability and access to Level II drugs are a major challenge for HBC programs, due to cost, knowledge and legal restriction. The main drug for level II, codeine, is not easily accessible to HBC as it is a controlled prescription drug and may not be used by caregivers. Therefore, HBC clients with in need of Level II or Level III pain management are referred to nearby health facilities. A major challenge faced by HBC programs

is the lack of palliative care and pain assessment expertise at health facilities, which, combined with MOH drug stock-outs, does not demonstrate promising access to referred patients for pain medications. However, in some cases the linkage between HBC and health facility is strong and clients do receive the necessary medications.

Unlike HBC programs, hospices are legally able to access all levels of pain drugs. Most hospices use either codeine or Tramadol for clients with second level pain, and some can access Fentanyl, pethidine, or oral morphine for level III. Martin Hospice, which is closely linked to Choma District Hospital, had drugs from all three levels in stock and was giving them to patients as of March 2009. Some hospices also have pediatric formulations of pain relief medication. The CRS technical team has been conducting on site and on the job training in pain management drugs and their appropriate use.

In summary, over the last six months, CRS has monitored pain medication availability and has observed the following trends:

- Level 1:** 100% availability (Hospices and HBC)
- Level 2:** About 66% of hospices have at least one Level II drug available. Tramadol is more available than Codeine.
- Level 3:** 78% of hospices have at least one type of Level III drug in stock. Most have acquired morphine privately or through linkages with local government hospitals.

This information is reported monthly at USAID Palliative Care Forum and all-COPs meetings.

### **IR 1.2 Increased involvement of youth and family members, including men, in providing care for PLHIV**

Partners continue to recruit volunteer community caregivers, with special emphasis on identifying youth and male caregivers. Training and retaining youth caregivers has been challenging in that they are busy searching for ways of earning income. In the reporting period, Solwezi Diocese trained thirty male caregivers in Kabompo, of which seven were youths. Three other sites (Zambezi, Chinyingi and Chavuma) have identified an additional thirty men to be trained by the Diocese.

Three partners conducted a Small Test of Change (STOC) on increasing the number of male clients on the program. Small Test of Change is based on the concept of “Plan, Do, Study, Act” on a small initiative that addresses a programming gap, and then, if the initiative is successful, rolling it out on a larger scale across the program. Each partner was aiming to increase the number of male clients using VCT as an entry point for palliative care services. STOC sites were chosen based on places with low male uptake of VCT: Mpika Diocese chose two parishes, TAZARA and St. Andrew’s; Kasama chose Malole site, while Solwezi chose Mumbezi. ArchDiocese of Kasama tested 213 people and only 3 people tested positive. Only one of the three was male. Even though the result of the exercise in Malole did not yield the expected result i.e. raising the number of male palliative care clients, the number of people who tested was higher than the usual monthly average. Other partners have committed to trying STOC in their programs to increase male clients.

Caregivers continue to give health education to family members and hands-on training by involving them in caring for the clients. Family members are educated about care provided to the clients, and are the main information link between the community-based caregiver and facility-based ART provider. Caregivers supplement the work done by family members. Family members of the clients have an opportunity to mingle with patients and other clients' family members when they attend the monthly prayer day for the sick. At these monthly events, clients, family members and caregivers meet, pray and have a snack together.

### **IR 1.3 Increased service linkages with other provider organizations and programs**

SUCCESS partners continue to strengthen working relationships with their local DHMTs and district hospitals. Linkages allow coordinated support in ART, pediatric testing and care, PMTCT, higher level pain management and other emerging themes in palliative care. Partners are also linked to other CRS/USAID/CDC programs such as AIDSRelief, CIDRZ, and ZPCT for ART, RAPIDS for OVC support, CHAMP for OVC support, and New Start for palliative care referrals from VCT.

The program has continued supporting Prevention of Mother to Child Transmission (PMTCT) with an aim of supporting women and their partners enrolled in palliative care with education and referral for prevention of infection to children before and after birth. The project has encouraged male participation in PMTCT. Working with local DHMTs and government health facilities, some caregivers have been trained in dry blood spot (DBS) methodology for pediatric testing and they now collect samples for testing. Additional partners plan to train more counselors in DBS as a way of widening the base of capturing children who are eligible for palliative care. There is also a growing linkage between our partners and other PMTCT stakeholders improving referrals from those projects to our partners and vice versa.

All partners are encouraged to develop MOUs with these service providers to formalize relationships, which are often built on a personal relationship (which can disappear if someone is transferred) rather than an institutional relationship. However, partners have found that government institutions are reluctant to put any relationships in writing, even if the document is not legally binding. Despite this limitation, linkages continue to be formed and strengthened. Examples of strong linkages include Ranchod and Cicetekelo Hospices and their government hospitals, and Mongu Diocese with their DHMTs and area hospitals.

Over the last six months, SUCCESS Return to Life has supported increased linkages at national level. The relationship with NAC and Ministry of Health is maintained with personnel from SUCCESS and PCAZ attending key program forums. As part of preparing the True Colors Trust morphine pilot, PCAZ has further strengthened linkages with UTH, MOH, DEC, NAC, and member hospices. Although PCAZ has not greatly increased their membership base in the past reporting period, the organization has strengthened their partnership with existing members by holding quarterly membership meetings discussing pertinent issues such as advocacy, sustainability (including MOUs with Government) and accreditation. PCAZ also developed a website to increase their visibility, and started the process of developing a newsletter.

PCAZ forged ahead with an important linkage between hospices and the Cancer Diseases Hospital at the University Teaching Hospital. The process concluded with an amendment of the MOU between the MOH and PCAZ that defines a mutually beneficial relationship between

hospices and CDH. The MOU includes referring cancer patients between the hospital and hospice institutions for pain and palliative care management, and opens the door for resource and information sharing.

Internationally, PCAZ maintains linkages with APCA, Ocean Road Cancer Institute Tanzania, and Island Hospice Zimbabwe. The latter two organizations are expected to train Zambian partners in the upcoming six months. PCAZ attended the annual APCA meeting in March, providing input into the development of standards for palliative care and into defining the APCA-National Association relationship over time.

## **Strategic Objective 2:**

***Implementation progress: September 30, 2008- March 31, 2009***

The SUCCESS Return to Life Strategic Objective 2 is “Demonstrated progress toward sustainability of palliative care programs”. Under this SO are three intermediate results:

- **IR 2.1** Partners demonstrate an increased capacity to implement and manage sustainable and effective palliative care programs.
- **IR 2.2** PLHIV have increased a more meaningful integration in all aspects of programming.
- **IR 2.3** Creation of committed and supported volunteer force as caregivers.

Progress toward each intermediate result over the last six months is detailed in the sections below.

### **IR 2.1 Partners demonstrate an increased capacity to implement and manage sustainable and effective palliative care programs.**

#### ***Output 1: Improved standard of M&E reporting***

The SUCCESS RTL M & E system relies on the SUCCESS M&E unit, the M&E staff of the partners and the field staff (coordinators and volunteers) to collect and analyze information. The field staff at site level collects and compiles the data from the communities they work in and submit their reports to the diocesan M&E officers or the coordinators at the hospices. The hospice coordinators also collect the information from their records. The data is then submitted to the SUCCESS M&E office through the program officers assigned to each hospice or diocese. During the last reporting period, statistical reports were submitted by the partners to CRS every month and narrative reports every quarter. Reports from partners for the nutrition support program are also submitted to CRS on monthly basis. This information is then aggregated or subjected to various analyses and is then reported according to USAID requirements.

For the grant extension, the M&E plan was revised together with the monthly statistical reporting forms used to collect statistical data for the key performance indicators. The SUCCESS RTL M&E plan tracks program indicators in line with indicators outlined in the PEPFAR Indicators Reference Guide. These are mainly quantitative indicators. The M&E plan also outlines qualitative information to be reported on by partners. The SUCCESS – RTL database used to capture and aggregate the data was also revised to accommodate the new indicators and desegregations. The M&E Plan was submitted to USAID, and received approval.

To ensure efficiency in the program's M&E system, refresher trainings were conducted during the reporting period for all program partners. The trainings were done on-site and the topics that were covered included overview and purpose of M&E, data quality and the importance of collecting consistent, accurate and reliable data. A total of 207 participants were trained from all the diocesan and hospice partners. The participants were site coordinators, assistant site coordinators, treatment supporters and caregivers. The diocesan M&E officers assisted in facilitating the trainings. The participants were also trained in collection of qualitative data to support the statistics that are submitted every month. In addition the participants were trained to use the revised M&E forms correctly. The training was aimed at building the capacity of all the partners in collecting data and reporting on performance indicators as well as appreciating the importance of M&E in program improvement. This is in line with the SUCCESS RTL sustainability strategy for the partners, which aims to ensure that they all have systems and staff in place to be able to continue all monitoring and reporting operations of the HBC program. It is anticipated that in the remaining project period, the data and reports generated will capture these new indicators.

Over the last six months, site visits to service outlets were conducted by the SUCCESS RTL M&E Officers and also the partner M&E officers in order to trouble-shoot, investigate data quality, conduct data validation and conduct various other monitoring tasks to assess program quality and effectiveness. SUCCESS Project officers and finance and compliance staff also undertook field visits to different partner sites. This helped to monitor partner activities and also to validate both the quantitative, qualitative and financial reports that the partners submitted. The partners meeting in November 2008 also provided an opportunity for SUCCESS to provide an overall M&E update to partners and address any concerns about reporting requirements.

### ***Output 2: Increased partner project management capacity***

SUCCESS RTL provided updates and refresher training on good financial management practices during this reporting period. Updates occurred at quarterly partners meetings, while refresher training was provided hands-on at the partner's office. Partners' financial officers and coordinators were equipped with skills to process liquidations of funds advanced to them with minimal questioned costs. Efforts were made to ensure that partners had viable accounting and financial management systems encompassing adequate segregation of duties. Project managers were provided with instruction on acceptable procurement procedures including the process of taking quotations for purchases exceeding valued at above \$500. In addition partners were given skills in budget monitoring to enhance their ability to spend their funds within acceptable timeframes without encountering cash flow difficulties.

During this reporting period all Diocesan partners received at least one technical assistance visit by SUCCESS RTL finance and compliance staff to help in identifying system weaknesses and identifying ways of addressing the same. The most common deficiency among the partners was filing, liquidation of advances issued to out-stations (parishes), insufficient justification of material and/or equipment issued to caregivers or clients and insufficient documentation of procurement processes. The Compliance Officer also identified a few fraudulent practices among partners' staff and recommended appropriate remedial actions.

PCAZ received additional support within this period to help them in enhancing their working relationship with other potential donors. They also received support in monitoring their work

plan which included delivering palliative care training for hospices and home based care staff, male caregiver training, applying for a Morphine roll out grant from True Colors and establishing a website.

***Output 3: Increased technical capacity***

This output focused on conducting trainings, and is described in sections under SO1.

***Output 4: Increased fundraising capacity for partners***

This output is described in the sustainability planning section, below.

In relation to accreditation, PCAZ continues to provide input to APCA on development of regional palliative care standards. Once the standards are finalized by APCA (anticipated by July 2009), then PCAZ will present them to the Zambian MOH for review, revision, and approval. These standards will serve as a benchmark for accreditation of hospices and other palliative care providers in Zambia. Therefore, until the standards are finalized, the accreditation process can not start.

**IR 2.2 PLHIV have increased and more meaningful integration in all aspects of programming**

***Output 1: Positive living groups are established and strengthened***

SUCCESS RTL has continued supporting caregiver and positive living groups in both hospice and community palliative care. The groups are carrying out meetings and activities of their choice and which they believe will keep them together beyond the project period.

Integration of palliative care with other livelihoods concepts remain a key activity in this phase of the project where emphasis on sustainability is stressed. CRS uses an approach to income generation activities called Savings and Internal Lending Communities (SILC). This methodology was piloted in two Diocese partners using CRS match funds for training, and to date over 30 groups with over 400 participants are actively involved in savings and have been oriented in small business skills to help them generate income for household support.

***Output 2: PLWHA represented in decision-making bodies***

SUCCESS continues to encourage partners to involve PLHIV in programmatic decision-making. Observing high turnover of staff in some partner programs, CRS recommended that PLHIV are recruited as caregivers, and also recruited for paid positions in HBC and hospice programs. In fact, many hospices currently do have PLHIV as members of their staff.

SUCCESS partners currently each develop their own caregiver incentive packages in order to maintain internal equity with other programs that they run. (For example, Mongu and Solwezi Diocese each support caregivers on both CHAMP OVC and SUCCESS programs.) Partners are encouraged to involve caregivers in deciding what to include in the package. In the last six months, SUCCESS has been a contributor to the Ministry of Health volunteer incentives survey, which is expected to put together a standard incentive or motivation policy applicable to Zambia.

Once a national policy or guidelines is in place, then SUCCESS partners will be asked to adhere to this across all their programs.

### **IR 2.3 Creation of committed and supported volunteer force as caregivers**

#### ***Output 1: Caregivers linked to small business training***

SUCCESS has supported two Diocese partners to train project volunteers, support groups and clients returning to life in the SILC methodology. Mansa and Mongu Diocese have to date trained over 30 SILC groups which are composed of an average 15 members per group. In Mongu, 85% of participants in SILC are female. These groups pool their weekly to monthly savings together and use this money as loan capital over a period of about a year and then finally share out the grown proceeds. Some of the participants eventually start their own income generating activities (IGAs). Current reports indicate a marked change in the livelihoods of volunteers and clients including OVC. These benefits have translated to improved sustainability of the home care programs with a better retention of caregivers. Female caregivers who are also the majority have benefited from this increasingly popular livelihood methodology. A SILC group in Mansa is now taking care of OVC at a day care centre where they also have an IGA of vegetable gardening.

CRS partnered with Peace Corps-Zambia to place an HIV volunteer with the ArchDiocese of Kasama Home-Based Care program to support training in keyhole gardens. Keyhole gardens are designed in way that they require little on-going effort to produce a large amount of vegetables for the household, as they are built with layers of compost and require periodic household waste water. The PCV trained sixty-nine caregivers in total, including all caregivers from two parishes closest to Kasama (St. John's and St. Annie's) and two caregivers from each of the remaining 16 HBC parishes. Each parish was then provided with tools (wheelbarrow, shovel, spade and fork set, and watering can, all purchased with CRS match funds) to be used for demonstrations and lend to palliative care clients to build their own garden. Each of the eighteen parishes were asked to also build a demonstration garden to use as a model for caregivers and clients to see, and packets of seeds were provided for these demonstration gardens, also purchased with CRS match funds. As of March 2009, six parishes (33%) had constructed demonstration gardens and five caregivers had constructed their own personal gardens. However, ArchDiocese of Kasama could not find any instance of a client having a keyhole garden, which was a disappointing outcome. While caregivers exhibited great enthusiasm for the methodology during the training, the reported barrier to building their own gardens was the amount of large stones required. At least one caregiver successfully used bricks instead of stones to overcome this barrier, while another experimented with building a shorter structure and had smaller output of vegetables as a result. In the next six months, CRS plans to conduct a small lessons learned exercise with the caregivers to identify other barriers to building gardens and will use this information to re-think future interventions. CRS also plans to meet with Peace Corps to debrief on the volunteer placement and identify other ways that the two programs can support one another at community level.

Photo 1: Caregiver training at St Annie's parish in keyhole garden technique.



Photo 2: Caregivers gather around a keyhole garden.



### ***Output 2: Trainings conducted for caregivers***

Partners are actively cascading training to caregivers, and CRS has ensured that all partners have funding for these activities. This information was shared in SO1, above.

### ***Output 3: Psychosocial support available for caregivers***

To date, partners are actively implementing their systems to provide psychosocial support for caregivers. Approaches include support groups, regular meetings, and prayer groups. Our Ladys Hospice in Lusaka uses a unique approach called Biodanza, which is a group activity that allows creative expression set to music.

## **SUCCESS RTL Cross-cutting Activities**

**Sustainability Planning with Partners:** SUCCESS RTL has continued to provide support to its partners in developing sustainability strategies to ensure provision of uninterrupted access to durable, quality palliative care services during and after the project. SUCCESS introduced a model for sustainability at the partners meeting held in November 2008. At the request of partners, a second workshop was held in January 2009 to discuss the four pillars of sustainability in greater detail: Technical, Organizational, Advocacy, and Funding.

Under each pillar, SUCCESS identified key outputs relative to palliative care programming, and partners were encouraged to identify additional outputs relative to their specific programs. An example of a technical output is “Partner assessments demonstrate they meet 100% of HBC minimum standards by July 2009.” An example of a funding output is “Partner has a written plan for how they will market their program to other donors.”

The partners developed action plans to ensure that they have addressed all the elements of sustainability missing from their organizations. Partners assigned activities, inputs, timeframe, and persons responsible for each output. CRS was not surprised to see the variation among sites in terms of the extent that they are or are not sustainable. Some areas, such as technical sustainability, required fewer activities for partners to achieve compared to funding sustainability.

The following describes the four pillars of sustainability in more detail:

**A. Technical:** High quality, equitable, cost effective programming is delivered, in collaboration with government and with the active engagement of local communities, through a dynamic and innovative approach that adapts self- sustaining models to ever changing conditions.

Technical sustainability focuses on the quality of care provided to clients, with emphasis placed ensuring standards of palliative care, identifying on-going training needs of caregivers, and access to pain medications.

**B. Organizational:** Capacity is achieved in administration, accounting, human resources, M&E, and effective leadership; sustainable organizational policies and procedures established

Organizational Sustainability includes development of strategic direction and planning, financial management systems, human resource management systems, supplies procurement and management, management of legal liabilities and record keeping. As part of current activities, the partners were encouraged to work on the caregiver – client ratio and determine if they were adequately staffed to meet the need at hand. Partners were provided additional funding to ensure that all their caregivers are provided with working tools like HBC kits, bicycles, gum boots and rain coats.

**C. Advocacy:** Capacity is established to advocate, communicate and network, including the capacity to generate local program evidence to inform policy makers regarding programming.

Under Advocacy and Policy Sustainability, partners were challenged to ensure linkages with local stakeholder and government structures. Partners were encouraged to affiliate themselves with organizations that would represent them to the government and raise their concerns relating to pain management, accreditation, and the rights of patients. Partners realized the importance of becoming members of PCAZ, which is charged with the role of advocating for palliative care and pain management in the country.

**D. Funding:** A diversity of local and external funding and support is sourced through demonstrating accountability, cost effectiveness, scalability and integration of programs

In Funding Sustainability, partners were encouraged to be creative in fundraising, using skills developed through workshops held in previous grant years. Strategies include involving the local private sector in providing support to palliative care ventures. Partners developed action plans which included improving fundraising and proposal writing skills, networking among stakeholders and developing business plans and marketing strategies. Our Lady's Hospice has continued to lead the way in soliciting funding and support from local partners like Zambeef

limited, GBM milling, Shabco Milling, Bank of Zambia, African Banking Corporation, Chilanga Cement, Phoenix Contractors etc. They also get support from a host of Diplomatic Missions and Religious congregations in Lusaka. Mother of Mercy Hospice and Human Service Trust have also taken a leap in local fundraising. During the reporting period they hosted fundraising dinners supported by the private sector. One gap identified through discussion was the lack of knowledge on cost-per-patient-day at hospices. CRS plans to address this challenge by organizing a costing study at one or more hospices in the upcoming reporting period. Despite past capacity-building efforts by CRS, partners still request more education on proposal-writing skills. CRS plans to address this challenge in the upcoming reporting period by sponsoring a ProPack training for interested partners (a CRS curriculum for proposal development).

As of January 2009, all HBC and hospice partners had individual sustainability plans. PCAZ also developed a sustainability plan. To support organizational sustainability, CRS worked with PCAZ to develop a job description for a Business Development Advisor consultancy position, to assist with strengthening a membership strategy, diversifying funding sources, supporting proposal writing, and recommending opportunities for the organization to decrease running costs. The consultant is expected to be identified in April 2009, and begin work in May 2009.

**National and International Conferences:** CRS sponsored six persons to attend the International Conference on AIDS and STIs in Africa, held in Dakar Senegal in December 2008 (2 from PCAZ, 2 from Diocese HBC programs, 1 Hospices representative, and one CRS staff). CRS also worked with our partners to develop and submit nine abstracts for the Implementers Conference, which will occur in June 2009, but unfortunately none were accepted. During the past six months, CRS attended the dissemination of the Zambian Demographic and Health Survey 2007. CRS staff also attended workshops to support HBC curriculum development and Pre-ART Package with NAC.

**Commemorative Days:** CRS partners marked World Hospice and Palliative Care Day on October 11<sup>th</sup> 2008 with community events and marches, caregiver recognition ceremonies, dramas, and hospice “open houses”. The culminating event was a gala held at Pamodzi Hotel, sponsored by PCAZ with SUCCESS funding, where policy makers, donors and palliative care providers came together.

CRS partners organized World AIDS Day (WAD) events in their respective communities on and around December 1<sup>st</sup> 2008. In Mongu, this important day was marked with the involvement of the HBC program in the district event organized by the DATF and PATF in the region; the event’s theme was “Leadership to stop AIDS! Keep the promise.” Among the activities carried out by the Diocese includes the holding of the ecumenical candlelight service at Our Lady of Lourdes Catholic Church on 30<sup>th</sup> of November. There was a prayer service held in memory of those people that have died due to HIV related illnesses, the HBC drama group also presented a sketch and songs; later speeches were given by various participating dignities. This interdenominational event was led by the parish priest and other members of the clergy from other denominations. There were over 500 people in attendance.

On the 1<sup>st</sup> of December, Mongu Diocese staff members, caregivers, care supporters (nurses) and site coordinators participated in the WAD March on 1<sup>st</sup> December from ZESCO premises to the stadium led by St. Johns Band. In this march, 443 project beneficiaries participated and they

included 369 adults and 74 youth. At the stadium, leaders gave speeches led by the PATF chairperson the District Commissioner, with entertainment provided by St. John's Band alongside other program drama groups, schools and church choirs from the district. Through Lewanika Hospital and care supporters in the SUCCESS-supported HBC program, a mobile VCT was available at the stadium all day where counseling and testing was carried out for those willing to be tested. This event was well-attended with an estimated 1,000 people believed to have participated. Other SUCCESS partners contributed to similar events in their districts.

**All-Partners Meeting:** CRS held two all-partners meetings. In November 2008, the focus of the three-day meeting was to share and dialogue on the extension priorities. Topics included reviewing palliative care standards, discussing packages of care for asymptomatic HIV positive clients, sustainability models, caregiver retention, small test of change methodology, HIV in the workplace, and M&E updates.

In January, partners re-convened for a three-day workshop on sustainability. Partners were informed that transition to the new USAID awardees for the next PEPFAR palliative care grant would occur from October to December 2009. Sustainability plans were therefore formed with a focus on achieving results by September, including preparation for smooth transition of all caregivers and clients to the new program. Each partner left the workshop with their own sustainability action plan, which was developed at the workshop and was ready for review by senior management at their respective organizations. Two months following the meeting, CRS sent a follow up communication to all partners to reinforce the importance of implementing their sustainability plans in order to be prepared for transition and the close of the grant.

The next all-partners meeting is planned for May 2009, and will focus on follow-up of sustainability planning by partners, updates on various technical palliative care areas, discussion of challenges to implementation, and activities planned for the next quarter, including the final evaluation and the client verification activity. By end of September 2009, all partners should be prepared to transition patients and caregivers to the next USAID awardee.

**Supportive supervision of partners:** Each diocese and the majority of the hospices received on-site visits from SUCCESS project officers following the workshop to follow up on technical focus areas of the grant and to provide supportive supervision to sustainability plan implementation. All visits to Dioceses were a combined technical-finance visit, so that communication related to partner workplans and budgets could be openly discussed and issues resolved in a timely manner. When not in the field, SUCCESS staff reviewed and processed partner narrative and finance report submissions.

**Human Resource Management:** This reporting period saw the departure of Chief of Party, Sonia Stines-Dereroncourt, who was replaced by Elizabeth Jere; and the Deputy Chief of Party, Sasha Angelevski, who was replaced by David Macharia. Colette Cunningham, Senior Technical Advisor, also left the project and was replaced by Robert Makunu as a Technical Manager. To ensure continuity and reduce disruption of activities, these changes were conducted over an extended period ensuring there was adequate transition between the outgoing and incoming personnel. Nonetheless, the new staff had to expend extra effort to familiarize themselves with project activities, acquaint themselves with the partners and understand the terrain in which they were to operate.

Other staff changes this reporting period were the departure of Monica Masonga, the Block Grants Officer, the arrival of Mwila Kangwa, Senior Monitoring and Evaluation Officer, and the arrival of Maureen Mwanza to take the position of Project Officer, Block Grants. To improve staff capacity within the therapeutic nutrition component of SUCCESS, three temporal members of staff were hired for three months (February – April 2009). This has tremendously improved program follow up on partner nutrition activities as well conducting five trainings within a short period of time. The grant plans to extend their contracts longer to assist with distribution and monitoring of the next batch of RUTF and HEPS.

In an effort to ensure better provision of service to partners, Project Officers were re-assigned partner monitoring responsibilities each according to his/her technical skills and experience. The reorganization is portrayed in the organization chart in **Appendix IV**.

**USAID relationships and requirements:** The three CRS SUCCESS RTL key staff, all of whom were new additions to the grant between August and December 2008, built relationships with USAID-Zambia and other PEPFAR partners. The Chief of Party represented SUCCESS-RTL at the monthly USAID all-COPs meetings, while the Technical Advisor represented CRS at the monthly Palliative Care Forum. Weekly meetings were held with the CTOR of USAID to discuss various palliative care and administrative issues. Grant requirements were met, including submission and approval of the final extension work plan and M&E plan to USAID. Quarterly accrual reports were submitted to USAID in December 2008 and March 2009. CRS coordinated three USAID visits to partners, one of which was a visit by Ambassador Booth to Serenje Parish HBC, under Mpika Diocese. The other USAID visitors went to Our Lady's Hospice and Ranchod Hospice.

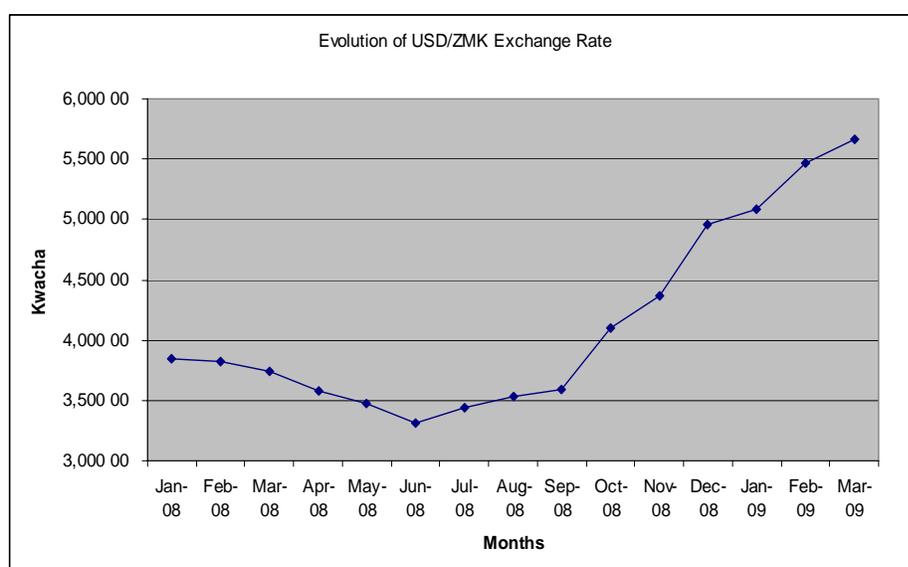
**Project budget:** SUCCESS RTL was due to end on September 2008 but was awarded a 15 months cost and time extension to run from October 2008 to December 2009. Additional \$6,220,000 was approved for the project bringing the total budget approved to \$15,970,000. To date a total of \$13,600,000 has been obligated while \$8,799,800 has been spent.

CRS provided pipeline reports to USAID and other financial information as requested during the reporting period.

**Table 2**  
**FINANCIAL PERFORMANCE FROM INCEPTION TO MARCH 2009**

Program Area	Obligated Amount	Expenses	Expenses	Expenses	Plan % (a)	Actual % (b)	(a-b) %
	July 06 to date	July 06 - Sept 08	Oct 08 - Mar 09	July 06 - Mar 09			
Palliative Care	8,840,000	4,610,700	1,329,281	5,939,981	65%	67.5%	-2.5%
C & T	2,720,000	1,261,832	380,299	1,642,131	20%	18.7%	1.3%
Adherence	2,040,000	966,954	250,734	1,217,688	15%	13.8%	1.2%
Totals	13,600,000	6,839,486	1,960,313	8,799,800	100%	100%	0.00%

**Figure 4: Exchange rate trends over time**



The low burn rate is attributable to fluctuation in the exchange rate and the delay in implementation of the food by prescription component of the project due to logistical challenges. The US Dollar has appreciated from a low an average of Kwacha 3,850 in January 2008 to the current 5,660. CRS is considering ways in which to improve spending in the upcoming six months, and will dialogue with USAID on ideas.

### Next steps

In the upcoming six months, SUCCESS Return to Life will continue progress on the work plan for the extension. All trainings planned by CRS and partners will be completed by September 2009. Partners will continue to incorporate Small Test of Change to recruit additional male clients. Scale-up of palliative care and VCT programs will continue in terms of enrolling new clients, although the number of service outlets is not expected to increase. The TF-CBT pilot will roll out community assessment trainings and therapist trainings, with M&E on the pilot process and results. The major focus of CRS will be preparing clients for transition, including compiling lists of all clients and caregivers, which will be verified by CRS. Partners will prepare for sustainability of their programs. CRS will prepare a close-out plan to present to USAID.

## **Appendix 1: Success story, April 2009**

### **Palliative care rebuilds confidence in a youth living with HIV**

Chipo struggled. The seventeen year old Zambian struggled with persistent respiratory infections, diarrhea, weight loss, and oral thrush. He struggled to take his HIV medications at school. He struggled to understand how he became infected with HIV in the first place. He struggled when his care needs sometimes fell through the cracks of his network of relatives, each of whom had the best intentions of providing care but had never identified a point-person.

Chipo was admitted to Martin Hospice six times in the past year. The hospice, a “place of rest”, provides free palliative care services for adults and children who suffer from life-threatening illness. Hospice staff receive skills training and PEPFAR funding from Catholic Relief Services, a USAID implementing partner in Zambia, to provide quality inpatient and community-based palliative care services.

Hospice staff attended to Chipo’s physical care needs, treating his infections, providing therapeutic nutritional supplements, and easing his pain. Networking with a nearby government hospital, the hospice changed Chipo’s HIV medication regimen, and identified dosing times to fit around his school schedule. Using skills from a Paediatric Psychosocial Counseling course, they addressed his emotional and spiritual concerns. The hospice educated members of his extended family on how to support Chipo more effectively. One of the hospice staff summed up the care approach: “Chipo taught us to look at him as an individual, and consequentially to support him holistically as he lived through this challenging time of illness.”

Chipo regained hope. His care team beamed with smiles when he told a visitor to the hospice that he wanted a bicycle. Upon discharge, he went to a different relative’s home, a person who was designated by the family as his primary caregiver, and he was visited daily by his uncle who observed him taking his medications. Hospice caregivers regularly visit Chipo at home, and are optimistic about his stabilizing health and regained appetite. Recently, a spontaneous donation from well-wishers raised just enough funding for a bicycle.

Chipo uses his re-gained strength to ride his bike with a new-found confidence; confidence arising from his personal accomplishment to manage HIV and confidence in his strong network of relatives and hospice caregivers to help him through any future struggles.

**Chipo and his bike**



## **Appendix II: Food by Prescription Rapid Assessment**

A summary of some of the major findings from the rapid assessment were as follows:

(a) *Food insecurity and nutritional needs*

In all the districts visited, there was evidence of food insecurity although the perceived extent and severity differed from one district to the other. It was reported by the majority of the informants that most community members in the rural districts experienced severe food shortages especially around the lean periods (October to January) when food had run out of their granaries. Furthermore, it was noted that many people in rural districts often lacked adequate finances with which to purchase food that would meet their nutritional requirements.

(b) *Food and nutritional challenges of PLHIV*

Malnutrition was perceived to be prevalent in all the five districts. For example at St. Francis, about 1 in 10 adults and about 3 to 4 in every 10 children would be severely malnourished. In Chilonga, about 5 in every 10 adults and 4 in every 10 children would be severely malnourished. Some informants observed that PLHIV were more vulnerable to hunger and for most of them, the physical appearance told the story.

The interviews suggest that children are more likely to present with severe malnutrition and most of them would be HIV positive. In all the hospitals, children with severe malnutrition are admitted in special children's wards where malnutrition is managed. The management of severe malnutrition consists of milk formula (F75/F100). Although most sites did not have any food supplements other than the milk formula, Siavonga had HEPS which was given to people with malnutrition. The HEPS and the milk formula given to children were provided by the World Food Program (WFP). This was so the only site where HEPS had been available. Other than Lusaka, in all the districts, it was felt that malnutrition was a big problem for PLHIV, especially for those on ART. For example, in Chilonga, it was observed that the nutritional status of most patients was extremely poor and that made it hard for them to effectively respond to treatment on time. It was estimated that 10 out of 50 adults on ART are likely to default due to lack of food. Thus, going by this observation, most people on ART are likely to default from taking their treatment due to lack of food.

(c) *Existing food supplementation program*

The hospitals visited exhibited different levels of experience with regards to food supplementation programs. Most of them derived their previous insight and experience about food supplementation from the World Food Program (WFP). What seemed to be common to all the facilities was that their supplementation programs were not well functioning as they did not have any food at the time of the assessment. Some of the hospitals visited have had no food supplements for over a year. In all the hospitals, the only food supplements that were available were milk formula for in-patient children with severe malnutrition especially those exposed to HIV. At some of the hospitals, it was reported that the previous and current food supplementation programs worked fairly well and proved to be of great benefit to the patients especially those on ART and with severe malnutrition. Despite the erratic supplies of supplements, it was observed that the programs assisted the hospital and patients in managing malnutrition.

(d) *Human and institutional capacity to implement FBP program*

All the hospitals visited expressed confidence and willingness to implement FBP program. The informants from the various hospitals said that the program was desirable and that they had the capacity to take on board the program and observed that, due to intermittent supplies of food supplements, the proposed program would greatly assist the hospitals in dealing with severe malnutrition among their patients on ART. Informants from all the hospitals said that they had adequate institutional capacity to integrate FBP program. Some said they had adequate storage facilities whilst some said they could find enough space for storing food supplements. For example, Chilonga Mission has adequate space at the pharmacy as well as a storage room near the kitchen. In all the sites, technical assistance in the implementation of FBP would be required although no additional staff would be needed. It was suggested that the best procurement system would be for CRS to purchase and deliver through the Medical Stores. There was a feeling that if the food was well packaged and labeled that it was a medicine, the chances of other household members sharing the food would be minimized as they noted that in the past, RUTF and HEPS was being shared by all the household members. Many informants indicated no concerns about stigma noting that if the patients were free to collect ARVs why would they be reluctant to collect food supplements through the pharmacy. It was evident from observations that staffs at these hospitals are too busy and overburdened by work. The ART clinics were the busiest but because of the desirability of food, all the hospitals welcomed the FBP supplementation program.

*(iii) Conducted baseline survey at all 9 health facilities*

The primary was to establish baseline measures to assess the nutritional impact of RUTF on severely malnourished HIV infected clients using a hospital based approach and the secondary objective was to document the rehabilitation trajectory of severely and moderately malnourished HIV infected clients using a combination of RUTF and HEPS. Three tools were used to provide triangulation for some variables especially the section on client screening and assessment practices/procedures by the health staff versus the exit interviews with clients.

### **Appendix III: Food by Prescription Baseline Assessment**

A summary of some of the major findings from the baseline survey were as follows:

(a) *Institutional Assessment Form*

- The baseline study found that most of the hospitals reported having the necessary human and institutional capacities to implement the pilot program, even though the data on trained staff and the numbers of those managing malnutrition was not fully captured. This was because some hospitals had difficulties placing people into categories of services provided due to overlap in tasks or nebulous job descriptions. Crosscutting – TB/malaria could be handled in different departments or could be considered opportunistic infections, etc.
- All the hospitals attend to PLHIV and provide ART and Care. However, the data on caseloads was difficult to collect as the records were either incomplete or unavailable, especially the records dealing with clients and management of malnutrition. More useful information for the FBP program such as defaulting and death rates were not really captured by institutions. Statistics related to malnutrition is scanty and may not really be used to reach any sound conclusions.
- Although the hospitals reported having adequately trained staff to identify malnutrition, the data shows that some of the important steps in screening for malnutrition were not mentioned by the staff - an indication that they do not follow the screening steps to the book. Furthermore, key measurements such BMI, MUAC and assessment for bi-lateral oedema are not routinely measured or understood by staff as being important or necessary.
- The foregoing finding could be true because only 32 percent of the health staff said they were trained to manage malnutrition. Many of the nurses said they were managing malnutrition, but had not been formally trained in malnutrition.
- Division of roles was a problem – nutritionists are rarely attached to the ART clinic so the clinic is not in the habit of linking clients to the nutritionist.
- Ailments such as diarrhea, constipation, thrush and nausea are not often asked when inquiring about nutritional related symptoms a client might have experienced in the last two weeks.

(b) *Client Exit Interview*

- Although the travel distances from homes to the hospitals were not indicated in most cases, the fact that 61 percent live beyond the village/township where the hospital is located means that they cover considerable to distances to access health services. Mean distances will be reported in the final report.
- Most clients came to the hospital because of chronic illnesses and the average number times they reported being to the hospital for the same episode of illness was three; whilst the median number of months they had been suffering from the health problem was 4 months.

- Client MUAC was not always measured and less than half (36%) of the clients reported receiving explanations as to why the measurement were taken. This is consistent with the institutional assessment data where health staff did not routinely measure MUAC, bi-lateral edema and did not calculate BMI.
- Less than a third (26%) were asked by a service provider about their nutritional-related symptoms in the last two weeks. Slightly over half (56%) were asked about their appetite compared to the health staff (37%) who mentioned this.
- Seventy-seven percent of the clients said they were satisfied with the services they had received. We acknowledge they may be some bias introduced since most exit interviews were conducted on the hospital premises, or where researchers are perceived to be health workers, thus dissuading clients from saying anything negative about the care they have received.
- Food security seems to be a major problem in all the sites visited. Less than half (40%) said they cultivate their own food but this food supply rarely is enough to sustain them through to the next farming season. Furthermore, slightly over half (54%) of all the clients ate less than three meals during the previous 24 hours.

(c) *Community Partners*

- Knowledge about malnutrition was high among the partners interviewed although when it came to causes of malnutrition they could not distinguish between causes and contributing factors – often responses were about “poverty” instead of eating the correct food.
- Only three individuals were able to correctly distinguish between severe and moderate malnutrition. As expected, most of the community partners are not health professionals and their technical understanding of nutrition is weak, in spite of the fact that most (77%) of them mentioned to have attended some form of training in HIV/AIDS and Nutrition.

## Appendix IV: Organizational chart for CRS-Zambia, SUCCESS Return to Life

### Notes:

- The organogram below illustrates only those staff dedicated on the SUCCESS Return to Life grant. It does not include temporary staff, such as the three nutrition short-term employees.
- Persons indicated with a dotted line are shared on SUCCESS with other CRS programs.
- The Chief of Party reports to the Country Representative at CRS-Zambia.
- Other CRS-Zambia departments provide additional support to the program on the basis of cost allocation (e.g. procurement, finance, logistics, administration, etc).

