



The USAID Micronutrient Program

## **Zambia Trip Report**

**December 2–5, 2000**

**Anne Roberts**



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The opinions expressed in this document are those of the author(s) and do not necessarily reflect the views of the U.S. Agency for International Development.

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## **Executive Summary**

The scope of work for this trip included the following:

- Work with National Food and Nutrition Commission (NFNC), Zambia Integrated Health Plan (ZIHP), and Central Board of Health (CBOH) to develop advocacy strategy and materials for Child Health Week (CHW); plan future behavior change communication (BCC) activities in support of child health.
- Examine ways that BCC can be used to simplify and remove barriers to CHW in the health care system.
- Discuss evaluation of information, education, and communication (IEC) materials with ZIHP-COM (Communications Division of ZIHP).
- Assist in completion of August 2000 mini-survey report.
- Review results of monitoring and evaluation over time for trends, new directions for inquiry.

The decision by UNICEF not to support the February CHW meant that a great deal of time was spent finding alternative sources and discussing new funding priorities for MOST. This may mean that the evaluation of IEC materials will be delayed for another funding period.

### **Recommendations**

1. MOST should provide the needed funding for the February CHW and should work with NFNC, CBOH, and other partners to find ways to cut costs and strain on the system while increasing the benefits.
2. As part of clarifying the cost/benefit of the CHW, MOST should support a cost analysis of the activity.
3. MOST and USAID need to agree on new priorities given the unexpected demand on MOST's budget for CHW.
4. MOST and NFNC should work together to develop a PowerPoint presentation that can be used for advocacy with CBOH, MOH, NGOs, and the press.
5. MOST should move quickly to arrange secure offices and computers set up for the resident advisor and the vitamin A coordinator. Despite their evident commitment and talent, both are unable to be fully productive given the lack of access to dedicated computers and quiet working spaces.
6. MOST and USAID should investigate ways to ensure the dedicated time of the vitamin A coordinator.
7. MOST should work with NFNC and ZIHP to re-focus mini-surveys and exit interviews to focus on IEC exposure and impact. After two years, it is time to review which materials are effective, what points need to be made, what barriers remain, and which issues have been dealt with successfully.

8. MOST, NFNC, and ZIHP should look at ways to begin including messages on micronutrient rich-foods. The evident success of the vitamin A capsule (VAC) distribution indicates that consumers value vitamin A and will take steps to assure that their children receive it. Based on this acceptance, messages explaining that vitamin A is also available in local foods could increase positive dietary practices.
9. NFNC, MOST, and partners should provide follow-up to support coverage/status of postpartum doses.
10. MOST and NFNC also need to check on the coverage/status of VAC used in treatment.

## **1. Purpose of Trip**

The scope of work for this trip included the following:

- Work with NFNC, ZIHP, and CBOH to develop advocacy strategy and materials for Child Health Week (CHW); plan future behavior change communication (BCC) activities in support of child health.
- Examine ways that BCC can be used to simplify and remove barriers to CHW in the health care system.
- Discuss evaluation of information, education, and communication (IEC) materials with ZIHP-COM.
- Assist in completion of August 2000 mini-survey report.
- Review results of monitoring and evaluation over time for trends, new directions for inquiry.

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## 2. Findings

### **ZIHP:**

Peter Eerens, chief of party, reports that he feels more optimistic about making the CHW easier and more part of the system. He bases this on the growing ability of the districts to recognize needs (for prevention) and adopt new activities and solutions (CHW).

### **Funding for CHW:**

A major issue during this visit was the decision by UNICEF not to provide the funding for the February CHW as they have done for past CHWs. Apparently, the funds provided for the August distribution have not been reimbursed by the Micronutrient Initiative, leaving UNICEF with inadequate funds for February. There are also doubts on the part of UNICEF about the use of an outreach model that they feel does not fit into integrated services.

As a step toward institutionalization of CHW into the regular MOH system, MOST and NFNC have searched for ways to decrease both the cost and strain on the system of this activity. In the past year, greater use was made of the new provincial staffs, who carried out the orientation at district levels with one or two central-level specialists. In the February distribution, the provinces will again take the lead in training or supervising the districts and the training of the health centers. If possible, only those districts that had low coverage for vitamin A and/or immunization would require orientation this round. IEC materials developed for the August round will be used for February with one new poster encouraging fathers to take a more active role. This has the dual advantage of saving funds and making the materials available on time for the first time. The monitoring reports consistently report that a barrier to good coverage is the late arrival of IEC materials and the lack of adequate orientation to these materials for the workers who will be using them.

Another barrier is the late or non-arrival of funds. A major effort will be made not only to get funds in country in time, but also to arrange for a funding mechanism that is less cumbersome than those used in the past. Failing other sources, MOST is prepared to fund the CHW, but this means that several activities already planned will need to be canceled or postponed until the next funding period when funds may be available.

A model for the future might be the one operative in other sectors, where training or orientation is provided only to those districts, centers, or workers who need the training. This would substitute for the current pattern of training all or most workers every six months, which at this point may no longer be necessary. Decreased funding for training would provide more funding for district activities, thereby decreasing stress at the district level.

### **IEC materials:**

A major problem in the past has been disseminating materials on time, due largely to problems with getting approval at the central level from the various committees involved. It was decided to have a meeting billed as final approval for the materials and to hold to decisions made at that meeting. This will provide time for the materials to be seen and used during orientation and to reach centers in time to be appropriately directed.

A new jingle promoting CHW (rather than simply vitamin A capsules) will be developed and aired during the run-up to the February round.

**Role of CHW in meeting Zambian health care needs:**

Findings from the August round showed that 119,000 immunizations were given, representing around 30 percent of the missed opportunities for these cohorts. Four hundred and four thousand children were weighed and, of these, health workers were able to identify 11 percent who are faltering. Other interventions included malaria prevention and tetanus toxoid (TT) for women of reproductive age. This suggests that CHWs provide an invaluable platform not only for missed opportunities but for reaching populations, such as the two-to-six-year-old child or the reproductive-age woman before her pregnancy, who cannot be contacted easily, if at all, by other feasible means. The NFNC acting executive director has pointed out that in the current stressful situation in the health care system, understaffing and under-supply of drugs or other essentials has made it difficult for health centers to deal with services other than urgent treatment and care. They have been forced into a triage mode that does not leave time for preventive services. The CHW provides a needed and possibly essential mechanism to provide these services at this time in Zambia.

**Advocacy materials:**

MOST Zambia sees advocacy to CBOH, MOH, and NGOs as a major need. A more supportive attitude and practices at CBOH would make implementation easier and would encourage local district staff in their efforts. Roberts worked with in-country MOST staff to develop a PowerPoint presentation that can be adapted to each of these groups (see Appendix B).

**Fortification materials:**

Posters, point-of-purchase materials, and stickers have been developed for fortified sugar but have not yet been released, pending the start of the new monitoring program. We discussed having senior USAID and MOH officials present them during a formal handover of the materials to Zambia Sugar. This should take place early in the new year.

**Postpartum doses:**

The current focus for MOST, NFNC, ZIHP, CBOH, and others is on the under-six distribution, but postpartum doses for women following childbirth provide the earliest possible protection for both mother and child during the hazardous postpartum period. While Zambia has adopted a policy of providing postpartum doses there does not seem to be an established policy to carry this out. There is also no agreed upon way to record or report coverage, which makes it difficult to know what is happening. The obvious mechanism is to use the BCG contact, with coverage over 85 percent, usually occurring in the first four weeks. The other opportunity is at birth, especially for women who deliver in hospitals or fixed facilities. MOST and NFNC will work with CBOH, MOH, CSI, ZIHP, and MNH to develop reporting and delivery systems that can be relied upon.

### 3. Recommendations

1. MOST should provide the needed funding for the February CHW and work with NFNC, CBOH and other partners to find ways to cut costs and strain on the system while increasing the benefits. MOST resident advisor and the vitamin A coordinator have already found several cost saving measures, linked to greater reliance on provinces for orientation and supervision, and to a need-based approach to orientation and training. This new approach focuses on districts with low coverage for vitamin A capsules (VAC) and for measles, since CHW has an important role in increasing immunization coverage. This approach also supports the Government of Zambia's new focus on provincial based decision making and programming.
2. As part of increasing the cost/benefit for the CHW, MOST should support a cost analysis of the activity. This should be completed in time for the findings to be available for IVACG in February and should look at man hours expended, as well as funds used. If CHW requires staff to work inordinate hours in preparation and implementation then it cannot be sustained.
3. MOST and USAID need to agree on new priorities given the unexpected demand on MOST budget for CHW.
4. MOST and NFNC should develop PowerPoint presentations to advocate with the CBOH, MOH, NGOs and the press, in order to build support for CHW.
5. MOST must move quickly to arrange secure offices and set up computers for the resident advisor and the vitamin A coordinator. Despite their evident commitment and talent, both are unable to be fully productive given the lack of access to dedicated computers and quiet working spaces.
6. MOST and USAID should investigate ways to ensure the dedicated time of the Vitamin A Coordinator. Despite dedication to production of the regular monitoring reports, the Coordinator finds it difficult to find time away from other demands on his time. These reports are an important product of the project, to NFNC as well as to MOST, USAID and the donor and program implementation community.
7. MOST should work with NFNC and ZIHP to re-focus mini-surveys and exit interviews to focus on IEC exposure and impact. After two years it is time to review which materials are effective, what points need to be made, what barriers remain, and which issues have been dealt with successfully. If it then seems warranted, MOST will work with partners to evaluate the impact and make recommendations for future IEC efforts.
8. MOST, NFNC and ZIHP should look at ways to begin including messages on micronutrient rich foods. The evident success of the vitamin A capsule (VAC) distribution indicates that consumers value vitamin A and will take steps to assure their children receive it. Based on this acceptance, messages explaining that vitamin A is also available in local foods could increase positive dietary practices. It will be important to find foods that are acceptable, affordable, available during much of the year, and that will be given to small children. Many foods, such as green leafy vegetables, are difficult to

prepare for small children, or may be considered inappropriate for them. In discussions with ZIHP it was decided that such messages, while linked to the success of the VAC distributions, should not be aired during the lead-up to CHW, when they might dilute the message, but should air at other times. There may need to be consultations and review of the literature to find the most appropriate foods to recommend.

9. NFNC, MOST and partners should follow up and provide support for postpartum coverage/protocols. We have been focusing on assuring VAC for under sixes. The postpartum dose is included in policy here, but there does not seem to be a clearly defined mechanism to deliver it or to capture coverage. The new forms developed by ZIHP and in use nationally do record the doses, but this information is not reported to the national level. It is not clear how the data are used at the clinic or hospital level where it stays. There are two obvious mechanisms that MOH could start with, providing the dose at delivery when it occurs in fixed facilities, and with the BCG, where the coverage is an excellent 87 percent. It appears that the first mechanism is sometimes used, but the second has not been considered. One difficulty would be in recording the dose if given with the BCG, since the newly designed child card does not have a space for the dose. Since, however, it is seen primarily as a child health intervention, to increase vitamin A levels in the maternal milk, this dose could be added to the child card, or simply noted on it until time to develop a new card.
10. MOST and NFNC need to check on the coverage of VAC which is also used in treatment. New protocols include VAC treatment for measles, diarrhea and malnutrition, and initially, the medical system found use of VAC for treatment much more acceptable than for prevention, but up-to-date data should be collected.

## **Appendices**



## **Appendix A**

### **Persons Contacted**

#### **USAID**

|                 |  |
|-----------------|--|
| Stephen Hodgins | Senior Technical Advisor, Child Health, Nutrition, Malaria |
| Chipo Mwele     | MOST   |

#### **National Food and Nutrition Commission**

|                      |                                  |
|----------------------|----------------------------------|
| Priscilla Likwasi    | Acting Executive Director        |
| Chisela Katiwile     | Education and Communication Unit |
| Ward Siamusanta      | Vitamin A Coordinator            |
| Eustina Mulenga Besa | IEC                              |
| Freddie Mubanga      | Training                         |
| Noah Mapunsi         | Assistant/ MOST                  |

#### **ZIHP-COM (JHU)**

|                       |                |
|-----------------------|----------------|
| Elizabeth Serlimitsos | Chief of Party |
| Josephine Nyame       | IEC            |

#### **ZIHP-SYS**

|              |                |
|--------------|----------------|
| Peter Eerens | Chief of Party |
|--------------|----------------|

#### **CBOH**

Ms. Jenny Nerenda

#### **CARE**

|             |                           |
|-------------|---------------------------|
| Irene Banda | Health Sector Corodinator |
|-------------|---------------------------|

#### **LINKAGES**

Nomajoni Ntombela

#### **UCI**

Mrs. M. Banda  
Mrs. Siame

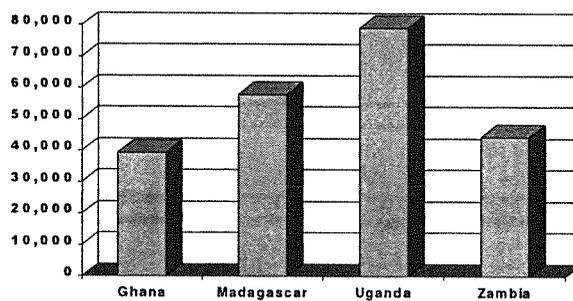


Appendix B  
Draft of Advocacy PowerPoint Presentation

**Benefits of  
Child Health Week (CHW)  
in Zambia**

**MOST**  
The USAID Micronutrient Program

Estimated Number of Preventable Deaths in Four African Countries among Children 6 Months-4 Years with Vitamin A Interventions  
Population studies - 1997-2002



## **Vitamin A Reduces Deaths from Measles and Diarrhea**

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Hospital studies in developing countries show that eliminating vitamin A deficiencies can reduce

- Measles deaths by 50 percent
- Diarrhea deaths by 40 percent

## **Eliminating Vitamin A Deficiency A simple solution to an overwhelming national problem**

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Benefits of achieving 80 percent coverage:

- Child deaths and serious illnesses prevented
- Decreased demand on already hard-worked health care providers
- Decreased demand for scarce drugs and services

## **Evolution of CHW**

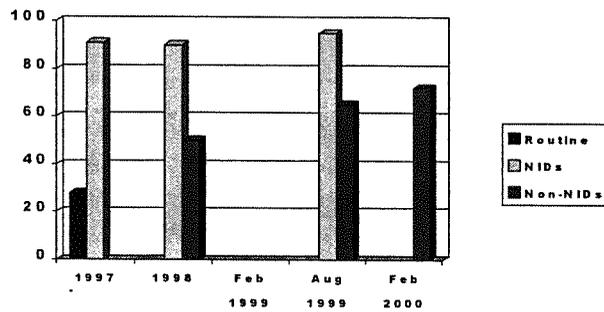
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- Survey in 1997 confirmed 66% Zambian children <6 deficient
- Integrated supplement and fortification program agreed upon in National MN Workshop as priorities
- Dietary change longer-term strategy

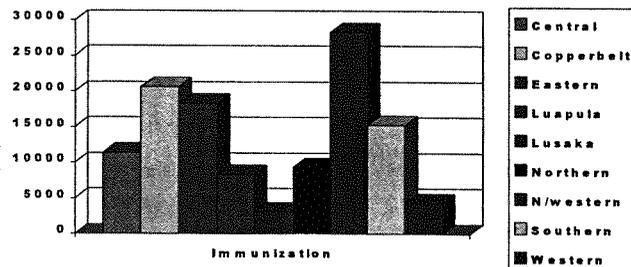
## Evolution of CHW (cont'd)

- VAC provided to fixed facilities for treatment and supplement
- Routine supplement achieved coverage of <30% in 1997
- First national non-NIDs distribution in 1998 achieved 65% coverage

### Improvement in Vitamin A Supplement Coverage



### CHW, February 2000: Number of Immunizations-119,000



## **Integrated Delivery of Child Services**

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### **IMMUNIZATION**

- Missed opportunities caught—30% of incomplete
- Potential to add 10% to full coverage
- Potential to complete immunization earlier

## **Platform for Immunization**

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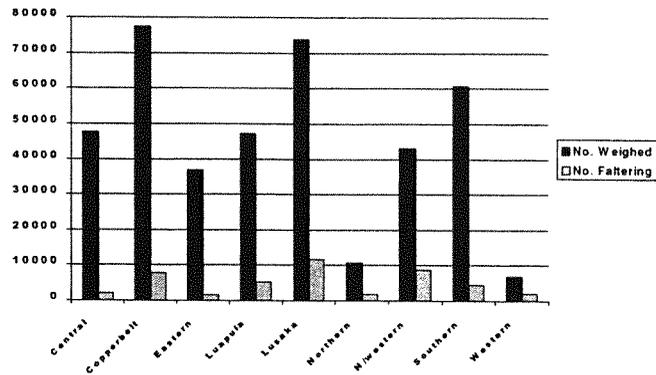
- More under-one's seen at CHW than seen by EPI
- Potential to complete vaccination of under-one's
  - more quickly
  - earlier

## **Benefits of Integration**

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- Hard or impossible to reach targets—TT
- Growth monitoring
- Malaria—re-treatment of ITN
- De-worming

## Growth Monitoring->400,000 Weighed 11% Faltering



## Contribution to Child Nutrition

- Over 4,000 faltering children identified in Feb. CHW
- Lists can be used by outreach groups for follow-up
- Program can pinpoint districts with greatest problems for special attention

## Positive Impact on System

- Measurable improvements
  - Districts adding to action plans
  - Logistics simplified
  - Fewer stock outs
  - Better quality of administration
  - Increased client knowledge of vitamin A value-50 % to 83%

### **Positive Impact on System (cont'd)**

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- Improved image of health services
- Mothers credit HW as best source on CHW
- Increased equity of access close to families
- Building partnership for health for prevention
- Increased male participation

### **Role in Health System**

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- Health care system under stress
  - under-staffed
  - lacking drugs and equipment
- HW focus on urgent care and treatment
- Little time for prevention or outreach

### **Role in Health Services**

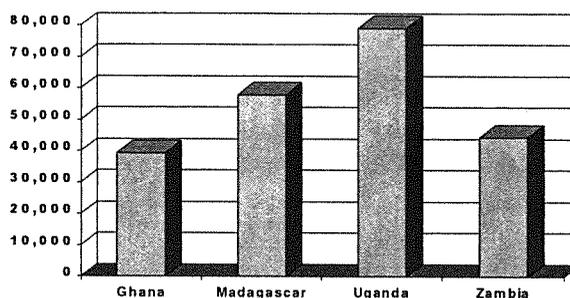
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- CHW provides platform for outreach and prevention
- Ensures access by preventive services to majority of children
- Mobilizes resources for preventive services twice each year
- Enables HW to identify high-risk nutrition cases
- Delivery of health education messages

## Different Delivery Systems for Vitamin A Supplements

- Routine under-five in Zambia
  - 1997 coverage--28%
  
- Routine worldwide--under 30%
  - No satisfactory model
  
- Periodic routine in Zambia
  - 78%

**Estimated Number of Preventable Deaths in Four African Countries among Children 6 Months-4 Years with Vitamin A Interventions**  
Population studies, 1997-2002



### How to Calculate the Number of Preventable Deaths in Zambia with Vitamin A Interventions

1. Calculate the estimated number of deaths among infants 0-1 yr. =  
estimated number of births x estimated infant mortality rate
  
2. Calculate the estimated number of deaths among children 1-4 yrs. =  
deaths among <5-(1) (as given in the UNICEF publication, State of World Children)
  
3. Calculate the estimated number of deaths among infants 6-11 mos. =  
 $0.15 \times (1)$
  
4. Calculate the estimated number of deaths among children 6 mos.-4 yrs. =  
 $(2) + (3)$
  
5. Calculate the estimated number of preventable deaths among children 6 mos.-4 yrs. with vitamin A interventions =  $(4) \times$  estimated % reduced mortality among children 6 mos.-4 yrs. with vitamin A interventions (use Beaton et. al estimated 23% reduction)

## **Gains in Deaths Averted**

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- At 80%, 18-23% of child deaths averted
- At 30%, at best 7-8% of child deaths averted. Probably less.
- Expected difference, xx child deaths





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