



ZAMBIA INTEGRATED  
HEALTH PROGRAMME

# **Zambia Integrated Health Programme Annual Report**

**October 1, 2002 – September 30, 2003**

**Submitted to:**

United States Agency for International Development (USAID)/Lusaka

**Submitted by:**

JHU/CCP-ZIHP COMM

Cooperative Agreement # 690-A-00-99-00014-00

JSI/R&T-ZIHP SERV

Cooperative Agreement # 690-A-00-99-00016-00

Abt Associates-ZHIP SYS

Contract # 690-C-00-99-00012-00

Society for Family Health-ZIHP SOM

Cooperative Agreement # 690-A-00-99-00228-00

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## Acronyms

AIDS	Acquired Immunodeficiency Syndrome
APHA	American Public Health Association
ARCH	Applied Research in Child Health
CARE	Cooperative for Assistance and Relief Everywhere
CBA	Community Based Agent
CBD	Community Based Distributor
CBGMP	Community Based Growth Monitoring Promoters
CBO	Community Based Organisation
CBoH	Central Board of Health
CCF	Christian Children's Fund
CCM	Country Coordinating Mechanism
CDK	Clean Delivery Kit
CHAZ	Churches Health Association of Zambia
CHIF	Community Health Innovation Fund
CHEWS	Community Health Waiver Scheme
CHW	Community Health Worker
ChwSrE	Community Health with Sister Evelina
Club NTG	Club New Teen Generation
CTO	Cognizant Technical Officer
DANIDA	Danish International Development Agency
DAPP	Development Aid from People to People
DfID	Department for International Development
DHMT	District Health Management Team
DILSAT	District Integrated Logistics Self Assessment Tool
EBA	Employer Based Agent
EPI	Expanded Programme of Immunisation
EU	European Union
FAMS	Financial and Administrative Management Systems
FP	Family Planning
FPLM	Family Planning Logistics Management
GAIN	Global Alliance for Improved Nutrition
GAVI	General Agreement on Vaccines Initiative
GMP	Growth Monitoring Promotion
GNC	General Nursing Council
GRZ	Government of the Republic of Zambia
HC	Health Centre
HCC	Health Centre Committee
HEART	Helping Each other Act Responsibly Together
HMIS	Health Management Information System
HIPC	Highly Indebted Poor Countries
HIV	Human Immunodeficiency Virus
ICT	Integrated Competency-based Training
ITGs	Integrated Technical Guidelines
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IR	Intermediate Result
IRH	Integrated Reproductive Health

ITG	Integrated Technical Guidelines
JHPIEGO	John Hopkins Program for International Education in Gynecology and Obstetrics
JHU/CCP	John Hopkins University/Centre for Communication Programs
JICA	Japan International Cooperation Agency
JSI	John Snow Incorporated
KAFHI	Kabwe Family Health Institute
KCC	Kasama Children in Crisis
LMIS	Logistics Management Information Systems
M&E	Monitoring and Evaluation
MOFED	Ministry of Finance and Economic Development
MoH	Ministry of Health
MOST	Micronutrient Operational Strategies and Technologies
MOU	Memorandum of Understanding
MSH	Management Sciences for Health
MSL	Medical Stores Limited
MTCT	Mother to Child Transmission (of HIV)
MVU	Mobile Video Unit
NAC	National AIDS Council
NDP	National Drug Policy
NDPSC	National Drug Policy Steering Committee
NFNC	National Food and Nutrition Council
NGO	Non Governmental Organisation
NHC	Neighbourhood Health Organisation
NIDs	National Immunisation Days
NMCC	National Malaria Control Centre
NPLWA	Network for Persons Living With AIDS
OPD	Out Patients Department
OPV	Oral Polio Vaccine
PA	Performance Assessment
PAC	Post Abortion Care
PWAS	Public Welfare Assistance Scheme
PAIDESSA	Pan African Institute of Development – East & Southern Africa
PEAK	Professional Exchange for Applied Knowledge Fellowship Programme
PHN	Population, Health and Nutrition Agency
PHO	Provincial Health Office
PHR	Partnership for Health Reform
PIR	Performance Improvement Review
PLHA	People Living with HIV/AIDS
PPAZ	Planned Parenthood Association of Zambia
PSI	Population Services International
QA	Quality Assurance
RBM	Roll Back Malaria
RNE	Royal Netherlands Embassy
RPM	Rational Pharmaceutical Management
SAGE	Stakeholders Advisory Group Expanded
SALT	Support and Learning Teams
SFH	Society for Family Health
SIDA	Swedish International Development Organisation

SM	Social Marketing
SP	Sulfadoxine/Pyrimethamine
SPA	Sectoral Program Assistance
SRH	Sexual Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendants
TDR	Tropical Diseases Research Centre
TH	Traditional Healer
THAPAZ	Traditional Health Practitioners Association of Zambia
TI	Training Institutions
TOR	Terms of Reference
TOT	Training of Trainers
TNA	Training Needs Assessment
TSO	Technical Support Organisation
UN	United Nations
UNAIDS	United Nations AIDS Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation
YAG	Youth Advisory Group
YAO	Youth Activists Organisation
ZAMSIF	Zambia Social Investment Fund
ZALON	Zambia Lobby and Advocacy Network
ZBCA	Zambia Business Coalition Association
ZCCP	Zambian Centre for Communication Programmes
ZEN	Zambia Enrolled Nurses
ZESCO	Zambia Electricity Supply Corporation
ZHABS	Zambia HIV/AIDS Business Sector project
ZHECT	Zambia Health Education Trust
ZIHP	Zambia Integrated Health Programme
ZNA	Zambia Nurses Association
ZNBC	Zambia National Broadcasting Corporation
ZWRASM	Zambia White Ribbon Alliance for Safe Motherhood

## Introduction

The Zambia Integrated Health Programme (ZIHP) is now in its fifth year of existence.

ZIHP supports the achievement of the vision of the health reforms and its strategic objective is the increased use of interventions related to child health, reproductive health and HIV/AIDS at the community level.

The programme is well embedded in the overall health care system. Yet, a results framework is the key factor behind the choices with regard to where ZIHP interacts with the health care system. In line with all former reports, results are documented, explained and commented against that background.

The programme supports activities at different levels of the health care system. Although it has a definite countrywide scope, it has also a geographical focus on twelve districts. Prioritised technical areas are fourfold: HIV/AIDS, Malaria, Child Health and Nutrition and Integrated Reproductive Health.

The programme collaborates with different institutions and statutory bodies. It supports activities in the public as well as the private sector and the non-governmental sector. It provides inputs for the continuous development of a broad range of managerial competences, and uses a variety of intervention strategies.

This Report covers the period from October 1 2002 to September 30 2003. The **Narratives** section provides the reader with information for each Intermediate Result. The report briefly describes the chosen *approach*, the *accomplishments* during the reporting period, the *implications* that arise from what has been accomplished so far, the *challenges* faced and eventual *modifications*. Throughout the accomplishments section, subtitles refer to corresponding sections of the Work Plan.

**Success Stories** have been incorporated throughout the report to illustrate the impact of ZIHP interventions at household and community levels. Further illustration is provided through brief summary reports of selected activities as well as tables and maps.

The **Tables** section carries more detailed information in bullet format. The *first column* contains the summary keywords of the corresponding subtitles in the Work Plan. The *Activities* column lists what has actually been done and the *Accomplishment* column addresses the “So what?” question. *Next steps* point to actions in the very short term while *Outstanding Issues* reminds the reader of which issues failed to be resolved.

This report is a joint ZIHP initiative. We thank all collaborators, partners and CTOs for the support.

## **IR1: Increased Demand for PHN Interventions Among Target Groups**

### ***A. Approach***

ZIHP aims to bring about behaviour change and to create demand for Population Health and Nutrition interventions among target audiences using a multi-media, multi-channel approach known as Behaviour Change Communication. This approach utilises a selected set of key messages designed to bring about the desired behaviour change. The focus areas in HIV/AIDS include risk reduction among youth, prevention of Mother to Child Transmission, reducing stigma and encouraging positive living. Reproductive health interventions promote family planning and birth preparedness for women and couples. Malaria prevention extends to early and correct care-seeking behaviour for children under five and pregnant women. Child survival interventions like Vitamin A supplementation, prevention of diarrhoeal diseases and immunisation are targeted at caretakers of children.

All Behaviour Change Communication activities are based on a strategic approach, with a consistent set of messages, and are designed to be mutually reinforcing. Interventions are designed in a collaborative environment, working through national technical groups. ZIHP works with the Population Information Education and Communication (IEC) Sub-Committee, the HIV/AIDS IEC Working Group, the NMCC and NFNC IEC Committees, and various other IEC groups.

Essential to behaviour change is altering perceived acceptability and the community norm around the behaviour. Family planning interventions show that when a woman perceives a high level of social support for family planning, she is more likely to adopt and sustain the use of this service. Similarly, the more families and communities talk about a subject such as HIV prevention, family planning, and immunisation, the more likely they are to adopt and sustain behaviour change.

The vision of the ZIHP behaviour change strategy is embodied in the health reforms slogan, "*It's You and Me for Better Health*". Communication is crucial to shifting attitudes and behaviours from the expectation of government providing the population with everything regarding their health, to a partnership, where individuals and the communities take responsibility as well.

### ***B. Accomplishments***

#### ***Increased Demand for HIV/AIDS Services (IR 1.1.1)***

##### **4A Campaign**

ZIHP commenced its mass media campaign with Zambia's First President Dr. Kenneth Kaunda featuring as the central figure. The first nine television and radio announcements were produced in Boston in November 2002, where Dr. Kaunda currently lived at that time. Broadcasting of these public service announcements started in the second half of December. In the announcements, Dr. Kaunda encouraged people to go for Voluntary Counselling and Testing and to overcome the

predominant stigma against HIV/AIDS. He also emphasized the importance of behaviour change to prevent infections and mentioned condom use as an effective way of doing so.

The second phase of the campaign was produced at the end of January also comprising nine television and radio spots, this time supported by advertisements in print and outdoor media. In this phase of the campaign, representatives of different sectors of the Zambian society joined Dr. Kaunda in the messages, which surround the same topics as addressed in the first phase. Among the people who featured in Phase II of the campaign were the Minister of Health, Dr. Brian Chituwo, Chief Mukuni of the Tonga tribe and St. Michael, who is a popular Zambian musician. Phase II of the Kenneth Kaunda campaign was broadcasted during the second quarter of 2003. Based on data from ZIHP's multi round survey, 74% of the youth in urban Lusaka remembered in August 2003 having seen the announcements of Dr. Kaunda. Fifteen press articles were documented in local newspapers discussing the campaign.

While the campaign generated overwhelming acceptance by the public and the Zambian government, ZIHP encountered some debate over a statement made by Kenneth Kaunda regarding the frequency of HIV infection within Zambia from the Bureau of Statistics. Prior to their inclusion, the statistics were passed by the Central Board of Health (CBoH) and United States Agency for International Development (USAID) and were calculated using conservative estimates. Nonetheless, Dr. Kaunda was compelled to make a simple statement on radio that the statistics in and of themselves were not important, but that HIV/AIDS is a fundamental threat to Zambian society. ZIHP received no further comment from the CBoH.

#### **Cross Borders Initiative**

HIV/AIDS communication is also intensive under the Cross-Border Initiative which covers six sites: Chirundu, Chipata, Kazungula/Livingstone, Nakonde, Kapiri-Mposhi and Kasumbalesa. The inputs from ZIHP consist of communication and health education and of sales of MAXIMUM condoms and *care* female condoms.

During the reporting period, ZIHP communications staff had multiple contact with over 100,000 persons within the high-risk behaviour category including commercial sex workers, truck drivers, informal traders, youth, and uniformed personnel. These contacts were made through a variety of means such as community workshops with church leaders, drama groups trained in Behavioural Change Communication (BCC) message design and participatory approaches for community sensitization, peer education for commercial sex workers and Queen Mothers on BCC concepts, and Truckers' nights for attracting transient populations to highly publicized events.

The activities aimed to reach widely variant target groups such as uniformed personnel from a cross section of military institutions, personnel from the Immigration and Zambia Revenue Authority, money changers and lorry boys. These groups continue to be sensitized on the dangers of Sexually Transmitted Infections and the need for early health seeking behaviour as well as the health risks of alcohol use. Traditional healers, village headmen and other traditional leaders have also been targeted to discuss their perceptions of STI.



### **Fishing Camp Project**

HIV/AIDS prevention is also key in the Fishing Camp Project, which started in March 2002. The two sites selected were Nchelenge and Samfya where ZIHP interventions target migrant fishermen and their female partners, a high-risk group that shows high rates of unprotected sex in non-regular relationships. The project is built on a strong component of interpersonal communication through outreach workers, and includes peer education and drama.

Under this component, ZIHP trained 36 outreach workers and peer educators to organize educational sessions, theatre productions, provide referrals for VCT and STI treatment and ensure condom supplies at the rural level for fishermen, traders and sellers. One of the major challenges to the project is poor transportation to cover the large catchment area. While the ZIHP-sponsored 'Love Boat' has greatly extended reach to distant islands, ZIHP is considering providing bicycles to the educators.

An extensive review of the project is currently being undertaken to improve management and supervision as a consequence of the dismissal of key local staff due to fraudulent use of project funds.

### **VCT Partnership**

ZIHP promotes Voluntary Counselling and Testing services under the auspices of a consortium of six organizations called the VCT partnership. ZIHP's role is to create demand for VCT in public sector health centres in 12 districts.

In June 2003, the Young Women's' Christian Association (YWCA) was awarded a sub-grant through ZIHP to strengthen the involvement of young people in the use of VCT. This programme targets youth, especially girls aged 16 to 24 years in Lusaka, Livingstone, Kabwe, Kasama, Chipata and Kitwe. ZIHP continues to manage a subcontract with Development Aid from People to People (DAPP) Hope Humana that supported the enrolment of 147 people in Positive Living Advocacy courses resulting in 65 graduates. There have also been an additional 171 people who have elected to participate in the course. A total of 435 people have been participating in Post Test clubs managed by DAPP with 91 counsellors participating in Counsellor Support Groups.

In December 2002, ZIHP completed a design of four posters around the central message "Free your mind". Ten thousand of these posters were produced and distributed during the reporting period. Other IEC activities were held including drama group performances, interpersonal communication, community events and mobile video shows.

### **New Start Centre**

With corporate funds provided by Population Services International (PSI), ZIHP opened a centre for Voluntary Counselling and Testing in downtown Lusaka in March 2002. The centre was opened by Dr. Kenneth Kaunda, who was also the first client at the New Start centre. Although funding constraints have limited the extent to which ZIHP has advertised the services offered, the centre still sees the highest number of clients in Zambia. After an evaluation of various VCT sites, CBoH supported the expansion of the New Start programme to all provinces with funding from the

German Government. This scale-up is scheduled to start in the second quarter of 2004. The programme is an adaptation of the New Start model, which was developed with USAID funding by PSI/Zimbabwe.

The number of clients at New Start has been largely influenced by television advertisement during the second and third quarter of 2002. Nevertheless, it is encouraging to see that even without any promotion, the centre sees about 600 clients every month. About 55 percent of the clients are individual males, 33 percent are individual females and 12 percent of the clients come in as couples. Forty percent of the customers are younger than 25 years. The high number of males confirms the demand for non-clinic based testing centres, since men are much less likely to visit a health facility for a VCT test.

### High Risk Group Survey

Other research activities conducted by ZIHP include a study based on interviews with high-risk groups (including commercial sex workers, their clients and other men and women who are likely to have multiple sex partners). The study looked at many different aspects of casual sex in Lusaka. One of the findings is that over 80% of Commercial Sex Workers used a condom during their last sex encounter with a client, but only 40% of the CSWs said that they always used condoms; 47% said they used them most of the time over the past twelve months.

#### Study on Folk Beliefs and Denial

Thirty in-depth interviews were completed with out-of-school males aged 15–19 years in 10 compounds in Lusaka, Zambia. Overall, awareness of STIs and HIV/AIDS was high, but specific knowledge about transmission, prevention, symptoms, and risk factors was limited. Most participants identified promiscuous, careless, and unhygienic individuals, especially women, as likely transmitters of STIs/HIV. Misconceptions about HIV being transmitted through mosquito bites, kissing, and biting were common as were folk explanations linking infection to the strength of individuals' blood, menstruation, or sorcery. Overall, risk perception among study participants was low. Denial appears to be the result of the stigma attached to STIs and HIV/AIDS, behaviours associated with infection, and conflicts between local values and youth's sexual behaviour.

#### Video on Stigma

ZIHP has developed a 40-minute film documentary to explore issues related to stigma around HIV and AIDS. The film provides a personal and compelling portrait of people who are both ordinary and extraordinary, in the face of this disease. Two families are portrayed (in their own words), to gain insight into the feelings of those infected and affected (including parents, children, siblings, and grandparents).

Seventy Five tapes have already been distributed to a variety of NGOs and other partners in Zambia, while numerous requests are coming in worldwide as a result of media coverage, including Frontlines magazine and Voice of America.

## ***Integrated Reproductive Health (IR 1.1.2)***

### **Safeplan**

ZIHP resumed its initiative “Operation Reach”, to increase access to SafePlan oral contraceptives, in rural areas. Under this initiative, ZIHP trains staff of public sector facilities on how to administer of SafePlan (a name created to over-brand Duofem for the Zambian market). Staff are also trained how to properly account for sales and purchases of socially marketed products.

The training under Operation Reach has been appreciated by the public sector health providers, because it empowers providers to offer women an alternative to generic Microgynon which is distributed free of charge at public clinics. Side effects of this drug have steadily driven up discontinuation rates. With training focused on counselling about discontinuation, side effects, myths and misconceptions, and the differences between Microgynon and Safeplan, providers are better equipped to combat these drop-out rates.

During the first six months of the reporting period ZIHP conducted five family planning-specific seminars for health centres from 20 districts in Eastern, Central, Luapula and Copperbelt provinces. ZIHP also conducted a training session for all health centres in six Southern Province districts. The training aimed to test the quality, learning impact and cost effectiveness of integrating the family planning and home water chlorination programs with the training required for the rural expansion of the Mama Safenite Insecticide Treated Net program.

This test demonstrated that integrated training not only resulted in more cost effective coverage of rural public sector facilities (in terms of cost per person trained per program), it also resulted in greater differences between pre- and post-test scores than family planning-specific training. In total, this training effort resulted in 250 health centres trained in 26 districts. Also it was demonstrated that integrated ITN, Clorin and Family Planning training is both cost effective and feasible.

In the second half of the year, ZIHP expanded the integrated training model to all 392 health centres in all 26 districts of the Western, North Western and Northern provinces. This coincided with a DFID funded expansion of the Mama Safenite ITN program, relying heavily on formal public sector partnerships. Pre- and post-test scores indicated lower base knowledge in Western and North Western Provinces, attributed to poor training coverage and high staff turnover in these districts.

Training may also provide a stronger entry-point to family planning for new users. Women have tended to seek provider advice on the use of a family planning product upon the recommendation of their family members. By increasing provider knowledge through these trainings, new users begin Safeplan with appropriate expectations, and learn where to find the product outside of the public sector facility. In urban areas where Safeplan enjoys commercial distribution through pharmacies, public sector training may feed private sector sales.

### **Child Health and Nutrition (IR 1.1.3)**

#### **Measles Campaign and Child Health Week Support**

ZIHP contributed to the review of the national strategy with regard to child health weeks. The review covered planning, implementation, and support of the child health weeks. It also covered monitoring and evaluation. The new strategy puts high emphasis on sustainability of the child health weeks. Timely planning and better pooling of the funding with existing basket funding are the main challenges.

Like every year, ZIHP provided technical and financial support to the conduction of two rounds of child health weeks in twelve demonstration districts. Activities undertaken included: Vitamin A supplementation, de-worming, immunization and growth monitoring and promotion. Improved partner co-ordination resulted in improved leveraging of resource. It also improved the cost effectiveness of the child health weeks.

*Table 1: Vitamin A Coverage*

Year	2000	2001	2002	2003
Coverage	72 %	83 %	89 %	>90 %

Data obtained from the child health weeks

#### **Measles and the National Immunization Campaign**

In collaboration with other partners, ZIHP contributed technically and financially to the success of the measles immunisation campaign. Support went into the development of the strategy document, of national planning and training for the campaign and in monitoring and evaluation of the campaign. The measles campaign was conducted in 8 provinces and was combined with other child health interventions, such as Vitamin A supplementation and de-worming. ITN distribution was included in 5 selected districts.

*Table 2: Results of National Measles Campaign*

Intervention	Target N	Actual N	Coverage
Measles	4,600,916	4,955,647	> 100 %
Vitamin A	1,713,923	1,864,818	> 100 %
Mebendazole	1,528,745	1,650,491	> 100 %
ITNs	13,275	14,895	> 100 %

Target populations: Vit A: 6-9 months, Mebendazole: 1-5 years; ITNs: 6-59 months in 5 districts.

In addition to the training, IEC materials were also produced as part of the pre-campaign activities: 36,500 Vitamin A posters, 32,500 de-worming posters, 30,000 de-worming leaflets, 30,000 vitamin A leaflet, and 20,000 GMP posters were distributed.

The success of the campaign was attributed to strong commitment of health workers and high level political commitment, to strong social mobilisation and good involvement of other sectors. Overall results show coverage above targets, most likely due to a combination of low census figures, inclusion of across border populations

and inaccurate age selection during the campaign. The campaign remains nevertheless a success.

### **Kabanana**

Until April 2003, ZIHP had sponsored Kabanana, a Zambian TV soap opera, which was used as a communication vehicle to promote health messages in a subtle and entertaining way. While HIV and Family Planning messages were woven in to the storyline, Clorin and ITNs were included in advertising form. After two years of collaboration, ZIHP ended this sponsorship in the second quarter of 2003. Since the quality of the series had decreased over time, it was felt that greater impact could be achieved by using new mass media programmes.

### **Vibrant**

ZIHP socially markets the multi-vitamin supplement *Vibrant!* under a pilot program in Copperbelt and Lusaka provinces designed to increase general knowledge about anaemia and its prevention. Previously, demand generation activities were confined to the 10 pilot health facilities and their surrounding communities. This was necessitated by delays in product approval by the Pharmacy and Poisons Board. However, through drama, peer education, provider and NHC trainings, ZIHP focused on increasing brand awareness, trial, daily product compliance and increasing repurchase rates.

KAP survey research conducted in 2002 indicates that *Vibrant!* has exceeded expectations in terms of brand awareness (77% versus 60%), product trial (34% versus 10%), and daily compliance (84% of those who have tried the product use it every day until the product runs out). Unfortunately, repurchase rates are still below expectations (25% versus 50%), indicating that women are either dissatisfied with the product performance, or strongly associate it with curative medicine. Qualitative research indicates strong product acceptance, and that the latter is true. Women strongly associate *Vibrant!* with pregnancy and health facilities, and as a product that *cures* rather than *prevents* anaemia.

Community-based activities focused on 590 peer education sessions, and training for 69 providers in 4 Copperbelt Districts and 83 NHC members from the pilot clinic communities in Kitwe district. This focus on interpersonal communications resulted in relatively small sales through pilot sites and commercial outlets in Lusaka and Copperbelt provinces until May 2003, when the product was finally registered by the Zambia Pharmacy and Poisons Board.

Mass radio advertising began in August in Bemba on the local Copperbelt radio station to serve the Kitwe pilot communities, and in English on National Radio, tagged with “available in Lusaka and Copperbelt only”. A new 30 minutes drama ran four times on Zambia National Broadcasting Corporation in September, and received strong coverage in the national print press. This coverage not only complemented the video quality, it demonstrated high recall of the video’s key messages.

### **Clorin**

Demand for the home water chlorination solution, which ZIHP markets under the brand name *Clorin* continues to increase much faster than expected. Clorin has become a household product widely used throughout Zambia. Increasing production to meet demand and avoid stock outs has proven to be the biggest challenge over time. Periodic stock-outs experienced in 2001 and 2002 resulted from insufficient bottle supply and production capacity and unexpected spikes in seasonal demand. Only one stock out occurred in January 2003, when ZIHP switched bottle and lid designs to a new supplier.

Beyond the January stock out, production remained just sufficient to meet significantly higher than expected demand between October and December 2002, and between February and August 2003 when sales increased 51% over the same period in 2002. To allow the three months required for ZIHP to build additional production capacity, communications focused more on generating correct and consistent use among current users rather than mass demand generation. At the same time, six new production machines have been ordered to increase capacity at all three production plants, and to enable ZIHP to build larger buffer stocks while eliminating the cost of overtime production.

Data from the 2001 Demographic Health Survey indicates that Clorin is underutilised in the most rural Western, North Western and Northern provinces relative to the urban Copperbelt and Lusaka provinces where distribution and communications are less expensive. Having reached near universal household awareness in more urban provinces, ZIHP began preparing for rural expansion by integrating Clorin with the ITNs to underdeveloped areas.

In September 2003, ZIHP introduced a consumer price increase from K500 to K800 per bottle to improve product cost recovery, and therefore sustainability, from 40% to approximately 70%. It is too early yet to predict the consumer reaction to the 60% price increase. If the new price is accepted without a major drop in sales, the production and packaging cost will be fully covered from sales revenues, which would also pay for part of the operation cost for this product.

### ***Malaria (IR 1.1.4)***

#### **Powernet**

ZIHP continued the Powernet program in Chipata, Lundazi and Chama Districts in rural Eastern Province, and began scaling down the same program in Kitwe, Copperbelt Province, as commercial efforts intensify there. This component of ZIHP's ITN programs has achieved high level of awareness among the target groups as well as satisfying coverage rates estimated at well over 40%. Market saturation and re-treatment supply issues both inhibited sales year.

Under the door-to-door model, health centres were consigned appropriate stocks of re-treatment kits by District Health Management Teams based on historical sales. Selected neighbourhood health committee representatives were trained on the door-to-door methodology and then provided with basins, up to 25 kits, and receipt books for

the nominal K500 fee charged per family for the re-treatment service. Treatment agents were allowed to keep the K500 fee as an incentive, once receipt books were returned and revenues audited by participating health centres. While this model allowed for no cost recovery to the District accounts to procure additional product, it is in line with current ITN partnership discussions to make re-treatment a public service requiring no purchase payment.

### **Mama Safenite**

Facing the re-treatment, management, and ownership challenges posed by the PowerNet program, ZIHP embarked on a second intervention targeting pregnant women and children with longer-lasting pre-treated ITNs under the brand name of Mama Safenite. Mama Safenite is sold at a subsidized price of K12,000 to K15,000 through Rural Health Clinics and NGOs throughout the country, one per antenatal or under 5 card. Sales on this program have been limited by commodities funding, and have required little true demand generation. As a result, communications efforts have focused on training for organizations to begin selling, as per the program design.

Since launching the Mama Safenite design in 2001, ZIHP has found it difficult to target communications and training activities in a cost-effective way that does not risk generating demand beyond the capacity provided by the commodities funding. By securing funding from UNICEF and DFID to support seed nets in 6 Southern Province Districts and the 26 Western, North Western and Northern Province districts, ZIHP was able to begin a concentrated training effort for every health centre in all 30 districts. This training focuses on the importance of targeting for consistent supply, biological vulnerability of pregnant women and children, and cash and stock management systems.

This concentrated expansion requires strengthened formal public sector partnerships between ZIHP, the National Malaria Control Centre, District and Provincial Health Offices. ZIHP signed a Memorandum of Understanding with the Central Board of Health in March, 2003, formalizing its role as implementing partners under the ITN component of the National Malaria in Pregnancy Initiative. In this role, ZIHP is responsible for creating efficient and effective distribution systems, for providing consistent supply of ITNs to participating districts, and for technical assistance in promoting appropriate and consistent use, cash and stock management, and monitoring and evaluation.

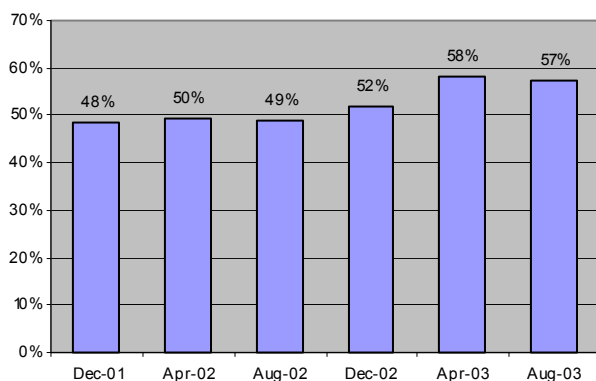
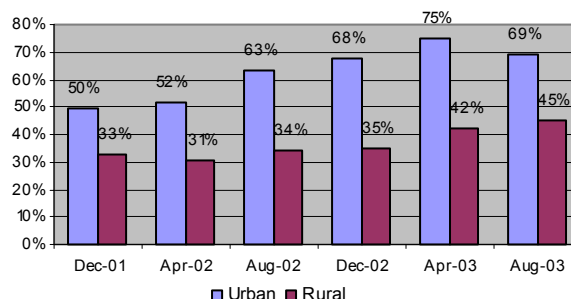
To avoid creating “vertical” programs, ZIHP followed this MOU with formal operating agreements with all 30 districts. These operating agreements clearly specify roles and responsibilities for ZIHP, the Districts and Provincial health offices, and were witnessed by the National Malaria Control Centre in rollout meetings in each province. Seed nets were provided by channelling funding through the CBoH Joint District Basket account to individual districts, with the expectation that they will manage their own funds. This design is intended to increase District ownership and accountability by operating within formal CBoH channels.

### Research Related to Communication and Behaviour Change (IR 1.2.3)

#### Multi-Round Survey

ZIHP continues to monitor its social marketing activities closely through a wide range of research activities. Of particular importance is the Multi-Round Survey which has been conducted in intervals of four months since December 2001. Six rounds of surveys were conducted up to August 2003. Each data point is based on 2,400 interviews of men and women in the 13 to 24 years age group who live in urban and rural parts of Lusaka district. Although each round is based on a smaller sample size than the one used for the Sexual Behaviour Survey and is limited to youth in Lusaka district, the multi-round survey measures impact of mass media interventions like the HEART or the 4A campaign. It can also be used as a monitoring tool to show trends in behaviour change more quickly than the larger surveys.

The adjacent chart is based on data from the Multi-Round Survey. It shows the substantial increase of recognition of Maximum Condom advertisements during the airing of the third phase of the HEART Campaign. The chart also shows the limited reach of television in rural areas.

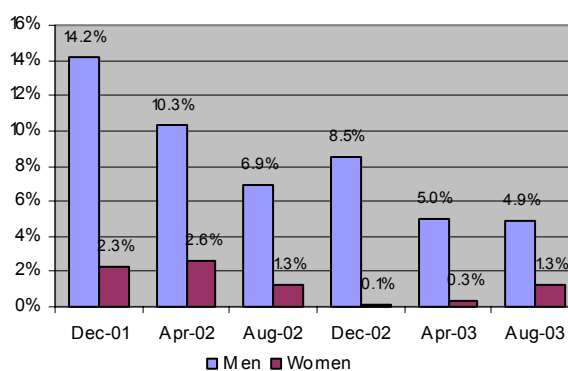


Another finding of the Multi-Round Survey is the increased condom use among regular partners and the decrease in casual sex partners. Despite the fluctuations between the individual rounds the data shows a clear trend towards healthier behaviour among the youth in Lusaka District. Particularly the decrease of reported casual sex among the surveyed population is coming out very strongly. This trend

is confirmed by the available data from the Sexual Behaviour Surveys.

The Multi-Round Survey also showed declines in the proportion of youths who were sexually active and those in casual partnerships. An analysis of the behavioral data shows that the intervention caused a postponement of the onset of sexual activity among both male

Figure 3: % Sexually experienced youth who reported sex with casual partner over the last 3 months





and female youths, thereby reducing the length of exposure to sexual risks. This may be particularly important for female youths, as it also reduces the risks associated with child bearing. Exposure to mass media campaigns had a positive impact on the use of condoms; viewers of the advertisements were found to have on average a more positive attitude regarding condom use than non-viewers.

### ***Health Promotion (IR 1.1.5)***

#### **Better Health Campaign**

The Better Health Campaign had a very successful year in terms of operations and implementation. The production schedule gained structure, resulting in improvements in quality and timeliness. There however, continues to be a problem with the talk show segment of the campaign.

This year, there was a new focus on production in rural areas to help pull the rural population into the programme. Evidence from the letters and quiz entries indicates an increase in submissions from rural areas. Details of the topics covered during the campaign are attached to annex 1.

About 20,000 copies of the “Health Matters” supplement on rural family planning was produced in July 2003 and inserted in the Times of Zambia newspaper. Three episodes of “Your Health Matters” and one episode of the quiz were produced and broadcast and four columns “To Your Health” appeared every Tuesday in the Times of Zambia. “Lifeline”, the talk show hosted by Frank Mutubila was produced and aired focusing on rural family planning.

A series of three posters were designed to cover the three topics highlighted: male and family involvement, integration of services including family planning myths and misconceptions.

### ***Youth (IR 1.1.6)***

#### **Youth Activist Organisation**

As part of the networking plan the Bauze youth centre Peer Educators visited the Youth Activists Organisation for half a day on the 11 July 2003. The exchange was intended to help the peer educators learn about YAO and its programs and how both groups can strengthen their work.

Two members of YAO staff travelled to South Africa to attend training on Qualitative Target Audience Formative Research. The training was organised and conducted by Soul City and held from the 18 – 26 May and 22-26 June 2003. As a result of the training, YAO was subcontracted by the Zambian Centre for Communication Programmes (ZCCP) and Soul City (South Africa) to pre-test the “Choose Life Magazine” for possible adaptation. The magazine will target school based young people aged 12-16.

YAO hosted the first Africa Advocacy workshop facilitated by the Youth Coalition of Canada and Youth Against AIDS Network of South Africa. The workshop was attended by 25 young people from different African countries. The objective of the workshop was to enhance young people’s skills to design and implement youth reproductive health advocacy programmes

The Projects Manager from YAO travelled to Nairobi, Kenya to attend the 13<sup>th</sup> ICASA conference from 21<sup>st</sup> to 26<sup>th</sup> September 2003, where a poster presentation was done entitled: *Mobilising Communities for Reproductive Health Through Football Camps*, based on the successes of YAO’s youth football and sexual reproductive health camps. An oral presentation titled: *Breaking the silence on HIV/AIDS through faith based youth Leader* was also given.

Chelston Clinic invited YAO participate in training conducted at the clinic. It was organised by the Lusaka Urban District Health Management Board in collaboration with the Centre for Infectious Disease Research in Zambia. A staff member from YAO facilitated training on HIV/AIDS transmission and prevention. The group of 20 participants was comprised of pregnant women who are part of the clinic’s Mother to Child Transmission + centre and people living with HIV. A peer-educators training was also conducted in Lusaka in for a group of 19 participants from Africa Directions. To date, 175 peer educators have been trained by YAO, many of whom have instigated new Sexual Reproductive Health activities across Zambia.

#### ZCCP Focus Group Discussions

Focus Group Discussions on the “Choose Life” magazine were conducted in Chipata, Lusaka, Kitwe, and Kasama districts. The discussions were productive regarding the magazine and what is acceptable for Zambian youths. The pre-tests were done in school with boys and girls that were both sexually and non-sexually active. Focus Group Discussions for parents and teachers were conducted as well.

#### Trendsetters

From October 1, 2002 to September 30, 2003, 100,000 copies of Trendsetters Commercial and 150,000 of the schools edition were printed.

*Table 3: Distribution of Trendsetters*

Month	Sales	Donations	Schools	Supplement	Totals
Oct-02	6900	355	50000		57255
Nov-02	7000	355			7355
Dec-02	0	0		40000	40000
Jan-03	8839	355			9194
Feb-03	9659	355	50000		60014
Mar-03	8846	355			9201
Apr-03	9477	355	50000		59832
May-03	9410	355			9765
Jun-03	0	0			0
Jul-03	9890	110			10000
Aug-03	9790	95			9885
Sep-03	9621	104			9725
<b>Totals</b>	<b>89432</b>	<b>2794</b>	<b>150,000</b>	<b>40,000</b>	<b>282226</b>

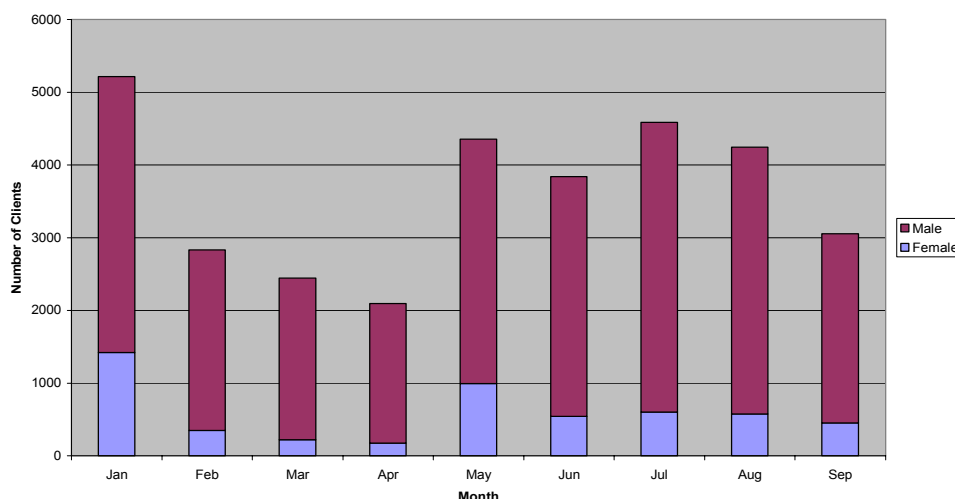
Youth Media recently secured funding from SIDA to conduct an evaluation of Trendsetters, with a view to scale up operations significantly. A Reader's Survey was conducted and printed in the December/January 2003 edition of the paper as a self-administered cut-out questionnaire. The 450 responses were analysed with the following results:

- 83% of respondents were between the ages of 16 and 25; 59% were male
- 97% believe parent-adolescent relationships would improve if both read the newspaper
- 93% reported that the newspaper had influenced their own behaviour

#### Africa Directions

During the passed year, the Bauze HIV/AIDS Community Youth Centre received 32,610 youth ages 3 – 25 and the average age being 15.9 years. The average number of youth who access the centre is now about 173 per day. These youth have received some form of information on HIV/AIDS, STDs and also have access to male and female condoms. The following are details number of youth who access the centre:

Figure 4: Clients by Gender



In partnership with other youth-serving organizations, Africa Directions has run several workshops on topics such as peer education, drama, and art (with funding from the Royal Netherlands Embassy). The youth centre has received numerous supplies from various donors, such as UNICEF and Cosmos Education. More programmes for children 5-8 years are taking place and has proven very popular even with parents. The children benefit from the personal attention and activities like singing, dancing, making drawings and group reading sessions. The number of girl peer educators has also increased, at present there are 11 females, a significant increase from 3. The total number of peer educators is 25.

#### Communication for Behaviour Change (IEC) Systems Development (IR 1.2.1)

ZIHP, in partnership with UNFPA produced 5000 of a youth RH/HIV/AIDS *Health Matters* newspaper supplement. The IEC materials included brochures on STDs,

HIV/AIDS and Stigma & Discrimination. In addition 7 different HEART Posters were produced.

### ***Individual Capacity Building (IR1.2.2)***

#### **Kabwe CBD Training**

In May, 20 CBD agents were trained in Kabwe for St. Paul's Sub Centre, a Catholic run school that does not allow for the provision of modern family planning methods. The CBD programme was initiated by the Community Development Officer working in the area, who in consultation with the community identified a demand for family planning services. ZIHP responded to the proposal by discussing and funding a one week training of CBD agents. Currently other areas are being looked at where there is a strong church-based network such as Solwezi in North Western province and Lubwe in Luapula.

Three Zambians were funded through ZIHP to attend the Advances in Family Health Communication Workshop in Baltimore. One staff member from ZIHP presented a paper at the Global Health Council Meeting and participated in that conference.

ZIHP assisted CBoH in formulating the curriculum which will be used for training District Focal IEC persons. With funding from the World Health Organisation, ZIHP will provide substantial technical assistance to implement the training. CBoH has recommended that following the initial round of training, the system be supported through a provincial structure, with regular updates and supportive supervision.

### ***C. Implications***

#### **Impact of Advertisements**

An encouraging finding of the Multi-Round Survey was that an increasing number of youth recalled messages that were promoted by ZIHP through TV and radio spots. The pattern of the responses followed the intensity of advertisements that were run by ZIHP, with a low in the second quarter of 2002 and an increasing trend in the subsequent periods. The multi-round survey further confirmed the correlation between people who have been exposed to ZIHP's media campaigns and those one who practice safer sex.

#### **Cross Border Initiative**

ZIHP will continue with targeted condom social marketing in the six border sites. However, it will be more careful in using mass media in this component and it will also make sure that any promotions run under this component are open to the general population and cannot be perceived as restricted to women, who engage in commercial sex.

#### **HIV Risk Perception**

The study based on in-depth interviews with young men concluded that misconceptions, folk beliefs, and denial can impede personal risk perception for

infection and interfere with the adoption of safer sexual behaviours. The findings from this study suggest several programmatic implications for improving young men's knowledge about infection and their subsequent risk assessment, including developing more peer-based interventions and presenting science-based messages that work within a local health belief framework. In addition, programs should work with communities to decrease stigma associated with youth's sexual activity and HIV/AIDS.

#### **Targeting of ITN subsidies**

Targeting of ITNs is a difficult concept to explain, particularly to the men who feel neglected under the program design. Given limited commodities funding for all ITN programs in Zambia, ZIHP focused on preparing providers to deal with these objections at the point of sale by explaining the importance of targeting if the health centre is to guarantee a consistent supply for the community of pregnant women and children. Dissatisfaction with stock-outs on other untargeted programs that have expanded too quickly beyond their commodities support makes this a more palatable explanation for the targeting when the objection is raised.

#### **D. Challenges**

1. The absence of formal studies make it difficult to gauge the success of the Better Health Campaign programme.
2. Africa Directions continues to identify transport as an on-going constraint, despite the acquisition of a vehicle nearly a year ago. Communication also continues to be an issue as the centre is located in an area of informal housing, where utilities, such as phone service are unavailable.
3. ZIHP has recently experienced significant challenges working with Youth Media. With the financial report over a year late, all funding has been suspended.
4. The results of the Multi-Round Survey suggest that negative perceptions regarding condoms and their efficacy are so deeply rooted that changes can only be seen after longer periods of consistent advocacy.
5. Another challenge is to reach consensus among government agencies about the content of mass media campaigns. The controversy about the validity of the statistics mentioned by Dr. Kaunda in the 4A campaign only served to distract the public from the main subject of the spot, the devastating impact that HIV has on Zambian society.
6. The fishing camp program had to be temporarily suspended after the Site coordinator and his supervisor were dismissed for forging hotel receipts. The program will be resumed over the next months, and will have to be closer supervised by Lusaka based staff. The case is a reminder of the potential conflict between creating a decentralized implementation system and enforcing sufficient financial controls.

7. Many sites that are supported by the VCT partnership, were faced with insufficient supply of HIV test-kits. A more reliable mechanism of supply needs to be worked out with Central Medical Store.
8. The significant reduction in the number of people accessing VCT services during the third quarter of 2003 in addition to the erratic supply of VCT kits, can be attributed to the strike action by civil servants during the quarter including health personnel.
9. In order for *Vibrant!* to deliver health impact above and beyond that offered by free iron folate, it is important that ZIHP uses communications to “normalize” the product as an everyday food supplement for women who are considering getting pregnant or in early pregnancy.
10. As with all ITN programs, achieving satisfying re-treatment rates remains problematic.
11. District ownership of the PowerNet program design remains suboptimal. Given the perception that PowerNet is a “vertical” program operating outside of the public sector systems, transferring programme management to the districts has proven a slow process.

#### ***E. Modifications***

1. The low re-treatment rates of ITNs severely restrict health impact. ZIHP has agreed with the NMCC to move away from re-treatable ITNs and promote long-lasting nets under the brand name Mama Safenite.

## **IR2: Increased Delivery of PHN Interventions at Community Level**

### ***A. Approach***

Activities to increase delivery of health interventions at community level strengthen the ability of Neighbourhood Health Committees (NHC), Non Governmental Organisations, Community Based Organisations(CBO) and other organisations in non-health related sectors to identify and to address problems at community level. A key input is training with a focus on HIV/AIDS, Integrated Reproductive Health, Child Health and Nutrition, and Malaria.

Districts within Southern, Eastern and Luapula provinces that would like to implement the NHC strengthening package are eligible for technical support from ZIHP

Through the Participatory Learning and Action training, the Basic Health Care Package has been significantly integrated into the structure and operations of NHCs and communities. All actions build on this foundation. Members of the community who volunteer to play a role in health promotion, are supported through training and through integration in a support structure in which CBOs, NGOs, Health Centres or DHMTs are the key players.

Scale up is achieved through different strategies: plain increase of coverage through multiplication of initiatives, involving the provinces, reaching out to other districts, or raising awareness of lessons learned at national level and facilitating action through out the whole health care system.

### ***B. Accomplishments***

#### ***Hold Meetings with Demonstration Districts to Review 2002 Action Plans (IR 2.1.1)***

##### **NHC Strengthening Package**

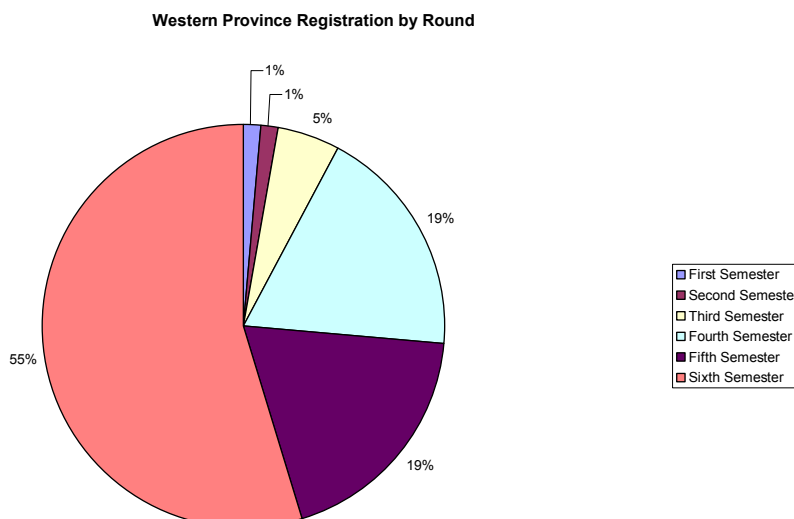
ZIHP's focus in the passed year has been on scaling up, beyond the demonstration districts, the NHC strengthening package. This has encompassed a Training of Trainers in Participatory Learning in Action, the Essential Health Care Package, distance education, operations research and case studies.

This year, the ToTs were held in all the provinces and districts that indicated in their action plan that they would be rolling out the training. It has been observed that a number of districts opted to roll out the training without informing ZIHP, such as Luanshya and Sesheke. Several districts have used basket funds to purchase radio cassette players and sets of audio cassettes with the "*Our Neighbourhood*" programme.

In a further effort to expand beyond the demonstration districts, the Distance education programme has been translated into Lozi and will be soon translated in Kaonde. Additionally, community radio stations were added to the broadcast plan

this year. Of particular note was the rapid expansion in Western province since the introduction of the Lozi programme at the end of 2002. Fifty five percent of all Western province residences that have registered for the distance education course have done so for the most recent round.

Figure 5: NHC Enrollment in Western Province



**Expand the Use of the Community Health Innovation Fund (IR 2.1.4)**

The Community Health Innovation Fund is a centrally managed pool of resources available to communities that want to implement innovative activities. The project is funded by the Royal Netherlands Embassy and very few communities have benefited from the fund. This year, ZIHP provided support to CBoH in organising a workshop to review the achievements of this fund and to reassess the criteria for accessing the fund. Provincial Clinical Care Specialists, DHMT representatives, and beneficiaries of the funds reviewed different aspects of Community Health Innovation Fund management. The sensitisation achieved through this review, has resulted in a tenfold increase in the number of applications per month.

The next steps are to support CBoH in printing and distributing the guidelines in booklet form and to help CBoH monitor the further development of this programme.

**Review of training packages (2.2.1)**

The intensive training activities that ZIHP supports at district level result in the continuous production of training materials for which the last stage is always the adoption by CBoH. Training materials can therefore be used countrywide by any organization that needs to train Community Based Agents. All training materials contribute to improved documentation of activities to be delivered at community and household level as envisioned in the Basic Health Care Package.



Many DHMTs requested training materials for traditional birth attendants. The TBA training manual used in demonstration districts was therefore updated. It only needs final adoption by different stakeholders.

Health providers in the private sector are behind in providing nutritional counselling. ZIHP therefore supported CBoH in designing an information package on nutrition that targets those health professionals.

In addition, a training package that helped community based agents promote social marketing products was developed in partnership with SFH. It focuses on basic skills in sales and marketing.

Finally, the finalisation of the following training packages is underway: HIV/AIDS education package for community educators, training package for community based distributors that address HIV/AIDS in Family Planning services, a Gender and Sexuality training package, a training package for home based care providers that addresses tuberculosis and People Living With AIDS friendly services, and finally an IMCI training package.

### ***Building capacities of DHMTs to train community based cadres and health centre staff (2.2.2.)***

Service delivery at community level relies on volunteers who receive basic training in order to be able to address different public health problems. The volunteers work under the supervision of the DHMTs or of the NGOs and CBOs that partner with districts.

Under the Community Partnerships program, ZIHP works with 12 DHMTs and 10 NGO/CBOs. More than a thousand trained Community Based Agents (CBAs) have been reached and trained through this program : whereas Traditional Birth Attendants and Community Health Workers are the two main types of community based agents, specific skills training results in a variety of agents: growth monitoring promoters, peer educators, community sanitary workers, malaria agents, home based care givers, community AIDS educators, etc.

The 1,481 CBAs that the program has reached so far, serve 1,6 million people, approximately 33 % of the total population in the demonstration districts.

Home based care givers were trained Lundazi (36) and in Kabwe (20). The training emphasised care and support for people living with HIV/AIDS.

Community HIV/AIDS educators foster dialogue on HIV/AIDS prevention strategies and on reduction of stigma in communities. In Kabwe, 20 of them received a refresher training

Gender and Sexuality training was organised for sub grantees in Kabwe, Kasama and Lundazi. In Kabwe and Lundazi, 44 teachers, head teachers and staff from the district education office received training in facilitation skills. This helped them address gender and sexuality among youths in their schools and communities.

Three training sessions were conducted that introduced 106 agents for the first time to service delivery skills. They will become community based promoters of growth monitoring, members of emergency transport committees, home based care givers or traditional birth attendants

In Kabwe and Mwense, 40 CBAs received training as sales agents for different commodities: PowerNet, condoms, Clorin.

ZIHP also provided support to DHMTs to offer refresher training of 185 existing CBAs: in Kasama, Chibombo, Kabwe, Kitwe, Kalomo and Ndola. Most often, the training is also open to their supervisors. DHMTs and their NGOs reported on the progress made by their CBAs.

In addition, 50 volunteers were trained in elementary bookkeeping. They came from Kasama Child Crisis Centre and from the Thandizani Community Based HIV/AIDS Care and Prevention Project. This activity helped them in ensuring that accounting records were well kept.

### ***Building capacities of DHMTs to supervise community based cadres and health centre staff (2.2.3)***

DHMTs play a central role in maintaining skills among different cadres. ZIHP, formerly less successful in addressing issues surrounding supervision, shifted this year slightly its strategy from supporting training to supporting supervision. Outcomes of that change have become evident in the districts. The supervision of CBAs is done through health centre staff or through staff from NGOs or CBOs and occurs more and more on a monthly basis.

During the DHMT's supervisory visit, register books and the data reported by CBAs are reviewed. When needed, on the job orientation is done for staff so that problems are immediately rectified. During this year, there has indeed been a slight increase in the number of CBA reports received: from 48% to 52% of reports expected.

In order to strengthen the supervisory skills a hands on training workshop for 39 CBA supervisors and CBA trainers was conducted for Livingstone and Kalomo DHMTs. This enabled them to share experiences, identify bottle necks to effective implementation and supervision of CBA activities. During the training possible solutions to these bottlenecks were discussed after which the group developed action plans to address the identified concerns and simple checklist that they could use during support supervision were developed. This will contribute to effectiveness of supervision of CBAs and to improved reporting of CBA activities to Districts.

Interesting results were seen in Kabwe and Kalomo. DHMTs ensured that health centre staff supported the CBAs: Kalomo DHMT purchased materials to restock the

traditional birth attendants with soap, razor blades, matches, lamps and paraffin. This has motivated TBAs to do their work. This idea has been shared with other DHMTs like Livingstone and Chibombo. As a result these districts plan to buy essential items needed by CBAs such as paraffin, candle and bathing soap. This will play a big role in motivating the volunteers.

In Ndola and Kasama, where communities may live 10 to 15 kilometres away from health centres, outreach teams use Community Based Growth Monitoring Promotion sites for delivering other services like immunization, family planning or antenatal services. In Ndola, the community based organisation Hosanna has strengthened support to CBAs by training one of the child health promoters in basic supervision. This helps in supervision, data and report collection and also increases mobilisation during community events.

***Build capacity for NGOs, CBOs, and TSOs in demonstration districts (2.3.1.; 2.3.2.and 2.3.3.)***

ZIHP has continued to strengthen the technical capacity of NGOs. On the job training, refresher courses and follow up visits are the most frequent inputs provided. As a result several NGOs are able to take leadership in planning and conducting self assessments related to the quality of their performance, and several of them provide excellent technical support to their CBAs during supervision.

There are indications that DHMTs are willing to adopt the self assessment that is used with NGOs. This Performance Improvement Review (PIR) is a community based review process that helps in timely implementation of corrective measures.

Sub-grantees received support during the Performance Improvement Review: World Vision, Zimba, KAFHI, the Archdiocese of Kasama, Kasama Child Crisis Centre, Lubwe Mission Hospital, Mambilima Mission Hospital, Development Aid from People to People, and Thandizani Community based HIV/AIDS Care and Prevention Project

In Kitwe a refresher training was held for accountants of 11 NGO and CBOs as part of the on going capacity building in grant management. This training also included the updating of NGOs on information regarding end of project close out procedures. As with the NGOs, the 4 CBOs Natubombeshe Nutrition group, Nkrumah, Mulenda and Moomba and Hosanna were supported during follow up visits and Performance Improvement Reviews. Hosanna staff are participating in the documentation of their CBGMP activities.

**Table 4: Performance and Improvement Review of NGO/CBOs**

Name and rank of latest PIR	Management and Organization		Supply System		Sustainability		Technical competence		Community Commitment	
	L1	L2	L1	L2	L1	L2	L1	L2	L1	L2
KAFHI ( Kabwe – 6 <sup>th</sup> PIR)	81	89	78	73	94	93	88	80	72	85
Natubombeshe (Kabwe 6 <sup>th</sup> PIR)	78	96	55	77	99	99	86	88	87	89
Nkrumah (Kabwe 6 <sup>th</sup> PIR)	80	98	72	98	96	99	80	93	82	92
Thandizani (Lundazi 6 <sup>th</sup> PIR)	79	80	53	74	75	95	79	81	76	94
WVI ( Kitwe 5 <sup>th</sup> PIR)	83	82	87	81	98	97	93	92	77	74
KCCC (Kasama 4 <sup>th</sup> PIR)	31	44	51	39	30	41	56	60	38	69
DAPP (Chibombo 5 <sup>th</sup> PIIR)	55	71	66	43	71	68	62	79	49	70
Mulenda (Chibombo 5 <sup>th</sup> PIR)	60	58	58	37	56	71	60	63	63	47
Moomba (Chibombo 5 <sup>th</sup> PIR)	55	72	50	67	75	62	59	56	37	49
Lubwe SMH (Samfya 5 <sup>th</sup> PIR)	76	73	82	78	88	89	68	68	64	62
Mambilima (Mwense 5 <sup>th</sup> PIR)	58	80	42	44	74	75	69	71	85	89
Zimba (Kalomo 4 <sup>th</sup> PIR)	76	65	76	64	69	74	81	73	68	66
Archdiocese (Kasama 4 <sup>th</sup> PIR)	62	79	69	82	65	87	69	72	78	79
Hosanna (Ndola 2 <sup>nd</sup> PIR)		80		43		73		66		79

The scores in the table indicate stable performance of the non governmental organisations involved in the delivery of health interventions in high risk areas. Organisational, management performance and program sustainability have remained stable and have sometimes improved. Supply systems have improved in some only. They are not the strongest component in NGO performance. Technical competencies have generally remained stable, and community commitment remained also the same. Organisations with a longer follow up, have on average a stronger performance.

An exceptional improvement in the delivery of health interventions in high risk areas was observed in Moomba. This is due to the full involvement of the church which now supplies drugs for treatment of opportunistic infections, funds for implementing behaviour change programs with young people and care givers, food for clients and bicycles for peer educators.

In an effort to improve capabilities of the participating organizations to manage the performance review efficiently, a three day workshop was organized that centered around computerized management of the performance data. This will reduce the time spent by the team to calculate scores in favour of the collection of qualitative information.

All NGOs/CBOs contribute substantially to increased use of health interventions, but some of them initiated initiatives that have now impact beyond their catchment areas.

Experiences like the Clean Delivery Kit have been translated into programmatic approaches that help in the overall implementation of the Basic Health Care Package. While Zimba and Lubwe Mission Hospitals have continued the implementation of the Clean Delivery Kit Program, DHMTs of Mazabuka, Itezhi-Tezhi and Kazungula, all in Southern Province, have been introduced to the programme with the help of the Province Health Office. All are now distributing their own kits.

In preparation for further scaling up of the Clean Delivery Kit program, a District Guide has been developed. During the launch of the annual planning cycle, the Guide has been disseminated to provincial and district managers. Provincial core teams for CDK have been set up. They will support the introduction of CDK programs in districts. The Southern Province team received the first training. North Western Province and Western Province followed later on, thanks to support from GTZ.

#### ***Clean and Safe Delivery***

*The 1998 Maternal Mortality Study in Zambia attributed 12.5% of the maternal mortality to sepsis, second to haemorrhage. In addition birth is responsible for two thirds of all neonatal infections. Zambia therefore identified clean and safe delivery as one way to reduce the maternal and neonatal mortality. This is important, since 53% of expectant mothers in Zambia deliver at home.*

*The Clean Delivery Kit Program addresses this public health problem. Zimba Mission Hospital and Lubwe Mission Hospital were the initiators of this program, but other districts have followed their example. Today all Provinces know about the programme and are interested to emulating what has been achieved in the Lubwe and Zimba catchment areas. Central Board of Health has included the CDK programme as one example of cost effective interventions that operationalises the Basic Health Care Package*

*The Clean Deliver Kit, assembled by the districts, include the following low cost items: a razor blade, three cord ties, one plastic sheet, one piece of soap, one pair of gloves, one candle and one matchbox.*

Lubwe and Zimba Mission Hospitals are also implementing the emergency obstetric transport scheme. More information about this is found under the section on improved referral.

#### ***Develop CHAZ capacity to support NGO activities in hard-to-reach areas (2.3.4 )***

The successful implementation of the Clean Delivery Kit programme in Zimba Mission Hospital has attracted interest of Churches Health Association of Zambia and an agreement to design such a programme for its member institutions was reached. Current efforts to scale up its implementation in other districts have overtaken this planned collaboration, and member institutions now benefit directly from the scale up at work through the Central Board of Health.

#### ***Improved referral systems in demonstration districts (2.4.1)***

ZIHP provides support to nationwide efforts to improve referral through emphasis on curriculum development and through training of health cadres and of community based agents. In addition, two activities focus on particular aspects of referral: the

support to better involvement of traditional healers, traditional birth attendants and other community based agents in referral practices. The second is the community based transport scheme in the catchment areas of Lubwe and Zimba Mission Hospitals.

The Lubwe and Zimba Mission Hospitals projects are in their third year of operation. The projects have achieved great ownership in their respective communities. District staff and communities attribute to them a great reduction of maternal mortality and a great improvement in referral for any emergency care.

These results were disseminated to Province Directors during the annual planning launch so that other districts could follow these examples. In addition, the experience gained in Lubwe and Zimba has allowed MoH and CBoH to collaborate with the Ministry of Local Government during the design of a national project on improved rural transport. The experiences in Lubwe and Zimba provide the Ministry of Local Government with concrete examples of practices to be promoted during the future implementation of this project.

### ***Improved Intersectoral Partnerships (2.5.1)***

Support to initiatives that strengthen intersectoral coordination has led to remarkable results in Lundazi where the District Administrator has taken up the challenge to coordinate the multisectoral response to HIV/AIDS prevention: an action plan serves as a basis for the activities. With some training inputs from ZIHP, skills in advocating better integration of gender and sexuality in community interventions have been added to the skills base of organizations involved in health. The community radio in Lundazi has now also a weekly radio broadcast on gender and sexuality.

ZIHP also helps DHMTs in mainstreaming gender and sexuality into HIV/AIDS work across all sectors. Focus group discussions were conducted with target communities to assess current perceptions on gender and sexuality and HIV/AIDS. This helped in developing appropriate messages for community discussions and for designing training programmes for teachers, head teachers, staff from various district offices or departments, like the Judiciary in Lusaka district.

Such activities have a major influence at local levels. They influence school policies with regards to HIV/AIDS and they promote discussions on sexuality, gender and HIV/AIDS prevention strategies that go beyond abstinence.

In addition, with financial and technical support from ZIHP, quarterly coordinating meetings for all stakeholders implementing health related initiatives have been undertaken in Kitwe, Ndola and Lundazi.

### ***District co-ordination of activities that involve health centres and communities (2.5.2)***

Districts received support during the 2004 planning cycle so that activities that involve communities and health centres were well anticipated and budgeted for. This required visits to each of the districts and close collaboration with representatives of communities, health centres, NGOs and CBOs and DHMTs.

ZIHP has collaborated with the Provincial Health Offices in supporting program implementation and monitoring in their respective districts

As reported elsewhere, ZIHP has supported the coordination, the preparation and the implementation at national and district levels of the Child Health Weeks. Twelve demonstration districts received support for social mobilization for those events.

### ***C. Implications***

#### **With regard to training and supervision**

Although chronic shortages of NGO and District staff, transport problems and limited supplies in some rural districts continue to hinder effective supervision, several district staff have made great efforts in developing a more sustained commitment to supervision. There is great need for ZIHP staff to help province teams to encourage those trends at a larger scale.

#### **With regard to Clean Delivery Kits**

The clean delivery kit is a simple response to a problem of essential hygiene. ZIHP faces strong pressure to focus on the scale up of the supply, while the success of the clean delivery kit is essentially a consequence of a facilitative approach towards problem solving. What needs to be scaled up is the capacity to address health problems in that way.

#### **With regard to Emergency Transport**

No hard data prove that the introduction of emergency obstetric transport influences maternal and neonatal mortality in the seven areas of Kalomo and six areas of Lubwe. But the local narratives indicate the clear contribution to individual risk reduction and the evident usefulness in other urgency contexts. The unanticipated synergy with a nationwide project developed by the Ministry of Local Government points to the need to ensure that the improved use of health services at community level goes hand in hand with improved policy and planning regarding referral systems.

#### **With regard to Performance Improvement Review**

The Performance Improvement Review process has been a very valuable tool in providing NGOs and their DHMT partners with objectively achieved qualitative and quantitative information on their performance. At this stage of the project, the unanswered question is the sustainability of such a method. The indications in the districts point to a useful link with performance improvement.

### **With regard to Gender and Sexuality**

There are signs that project interventions induce more positive approaches to sex education in communities, leading to more open discussions about sexuality within existing cultural contexts as shared in this quote from a community AIDS educator of KAFHI in Kabwe.

*” Fellow men will look at you as a person without traditional values and consider you as one having sex indiscriminately and governed by women. But now things are different. Men invite us to talk to them about gender, sexuality and HIV/AIDS”.*

This clearly points to the need to increase the incorporation of gender and sexuality as a required dimension in most interventions.

### **With regard to CBGMP**

The innovative approaches in addressing community based growth monitoring and promotion within the context of a concern for increased food security at community level are proving successful and have created a demand for the implementation of CBGMP by DHMTs.

The multisectoral nature of the CBGMP has not been easy to implement. But the recognition that successes like in Kasama can be achieved should encourage ZIHP to focus even more on strengthening the dynamics of intersectoral partnerships.

## **D. Challenges**

1. Several activities happened against a background of reduced funding throughout the first and second quarter. While some activities were cancelled temporarily or slowed down, most activities have been implemented later on.
2. A slow response to IRH issues at community level has been observed. One of the big challenges is to improve male involvement and participation of traditional leaders in some areas.
3. Whatever the progress achieved, regular supervision is still weak. NGOs are constrained by a lack of transport resources to effectively monitor and supervise their CBAs. Understaffing in the DHMTs is a big hindrance to effective provision of support to interventions at community level.
4. The success of the community based growth monitoring and promotion activities poses a huge challenge to similar facility based activities. There is need to invest in the orientation of facility staff in new concepts.



**E. Modifications**

1. Efforts were made to provide a better balance between support to training and support to supervision. This slight alteration of emphasis will continue and will be expressed in the work plan for year six.
2. The Performance Improvement strategy developed by CBoH provides an excellent framework for organising the handover of so many community based activities during the last year. It will be expressed in the work plan of year six.
3. Given the magnitude of current challenges, training of community cadres with focus on HIV/AIDS interventions needs to integrate ongoing activities that address other development needs.

### **IR3: Increased Delivery of PHN Interventions by the Private Sector**

#### *A. Approach*

Health reforms aim at realizing the full potential of the private sector in contributing to health. ZIHP provides therefore technical support to the training of service providers in private practice, be they non-clinical service providers or health workers. In developing the private sector, access to quality health services will improve, patients have more choices and self paying patients can obtain care of high quality.

Training covers priority technical areas like HIV/AIDS/STD, Integrated Reproductive Health, Child health and malaria.

In addition, social marketing provides a specific channel of service delivery. Expansion of the delivery of socially marketed products in the commercial sector is key. Utilisation of existing wholesale and retail trade channels continues. But next to these traditional channels of distribution, non traditional channels are also used: employer based agents or traditional healers contribute their share in stocking, promoting and sale of health commodities..

With the realization that approximately 80% of patients seek advice from traditional healers before going to the nearest health centre, there is great benefit in training traditional healers in identifying high-risk cases and in making timely referral to nearby health facilities.

#### *B. Accomplishments*

##### ***Refresher training of supervisors of Employer Based Agents (IR 3.1.1)***

Supervision and follow-up of health workers is a key factor towards providing quality services to communities. In this regard, ZIHP realised the need for improving the skills of supervisors of Employer Based Agents. A refresher training for health providers in the private sector was therefore held for supervisors, managers and information officers of the 12 districts supported by the programme. The event took place in Lusaka and attracted 42 participants, including traditional healers. Participants looked at the tools used for supervision, shared success stories of their programmes, worked on improving data collection and management, discussed ways of improving communication between ZIHP and the districts and identified solutions to the problems of supervision. Since then, there has been an overall improvement in the manner in which supportive supervision is carried out, in the frequency of transferring reports and in the quality of data received.

##### ***Training of EBAs (3.1.2; 3.1.3; 3.1.4)***

ZIHP has built on the successes of a programme started under Zambia Family Planning Services in 1996, and has worked throughout the years with employers and

DHMTs to improve the health of workers and to bring family planning services into the workplace.

Nine districts have been receiving training support for EBAs. This year, three of them requested for additional training sessions in order to replace EBAs who left due to transfer, retrenchment, disability or death. This led to the training of 65 more EBAs. In addition, four districts requested refresher training which this reached 91 EBAs.

The total number of trained EBAs now stands at 301. This concerns 233 workplaces, 43 of which were added to the programme during this reporting period (Lundazi: 15; Ndola: 14 and Kasama: 14). This translates in a ratio of almost 2 active employer based agent per 1000 employees. Information gathered during supervision show that EBAs who volunteered to learn skills in different fields, such as growth monitoring and family planning, were extremely innovative in their workplaces.

**Table 5: Districts, workplaces, trained EBAS and population reached**

<i>District</i>	<i>Workplaces</i>		<b>Number of EBAs trained</b>	<b>Number of active EBAs</b>	<b>Number of employees reached</b>	<b>Population reached</b>
	<b>2001 inventory</b>	<b>Currently in EBO program</b>				
Chibombo	21	12	30	30	11,000	64,900
Kabwe	38	19	24	11	15,851	93,521
Ndola	105	40	57	52	25,852	152,527
Kitwe	50	28	31	27	30,723	181,266
Kasama	32	38	40	32	12,821	75,644
Chipata	18	15	21	14	5,318	31,376
Lundazi	26	24	26	24	12,049	71,089
Chama	No program					
Kalomo	43	32	33	33	5,726	33,783
Livingstone	44	23	39	31	18,400	108,560
Samfya	No program					
Mwense	No program					
<b>Total</b>	<b>377</b>	<b>233 (62%)</b>	<b>301</b>	<b>254</b>	<b>137,740</b>	<b>812,666</b>

Note : Population reached = Number of employees x 5.9 children per family (DHS 2002)

The economic impact of HIV/AIDS has been very severe in most workplaces but the emotional impact on fellow workers is immeasurable. Workers watch sometimes helplessly colleagues wasting away and eventually dying. Often no qualified replacement can take over from them.

This has led to a change in the approach to dealing with HIV/AIDS in the workplace. Instead of just giving basic facts about HIV/AIDS, the refresher trainings of EBAs now focus on skills building in behaviour change communication, on how to deal with issues of gender, sexuality and on taking culture as a factor in HIV transmission. In addition, the following topics are now covered at length: Mother to Child Transmission (MTCT), Voluntary Counselling and Testing (VCT), Antiretroviral therapy, STIs and Care and Support of the infected and affected.

Many trained EBAs put into practice what they learned. Four EBAs in the hotel sector in Livingstone have created a very strong HIV/AIDS prevention programme with the assistance of their management. Equipped with behaviour change skills they reached out to all the Hotel employees and expanded their services to the nearby community of Chief Mukuni. In Ndola, EBAs have successfully encouraged companies to formulate HIV/AIDS policies at the workplace. These companies are large employers, often with headquarters in Lusaka.

Provision of Family Planning services at the workplace remains a major part of the duties of an EBA. This cuts down on the number of trips that employees have to make to a health facility to get their family planning supplies. It also helps reducing the number of people accessing family planning methods at already crowded health facilities. Employees have a better sense of confidentiality, as they access their supplies in a more private manner. EBAs distribute and give advice on oral contraceptives and condoms. They refer to health facilities for other forms of contraception.

**EBAs in Chibombo**

*EBAs who attend families of more remote commercial farms received extra training as Traditional Birth Attendants. The farms are far away from health centres and make it hard for the communities to access birthing services. The EBAs have filled the gap and offer this service to the community. One TBA visited was very happy to show the babies that she has delivered in her village. The DHMT has expressed satisfaction at the work done by these EBA/TBAs who give monthly reports to the DHMT.*

**Table 6: Couple Years of Protection achieved by EBAs from Oct 2002-Sept 2003**

District	Oral	CYP	Condoms	CYP	Total CYP
<b>Chibombo</b>	2,659	<b>177.3</b>	7,590	<b>50.6</b>	<b>227.9</b>
<b>Kabwe</b>	255	<b>17.0</b>	1,645	<b>11.0</b>	<b>28.0</b>
<b>Kitwe</b>	880	<b>58.7</b>	2,093	<b>14.0</b>	<b>72.6</b>
<b>Ndola</b>	2,137	<b>142.5</b>	14,049	<b>93.7</b>	<b>236.1</b>
<b>Chipata</b>	815	<b>54.3</b>	3,055	<b>20.4</b>	<b>74.7</b>
<b>Lundazi</b>	595	<b>39.7</b>	1,691	<b>11.3</b>	<b>50.9</b>
<b>Kasama</b>	438	<b>29.2</b>	3,216	<b>21.4</b>	<b>50.6</b>
<b>Kalomo</b>	892	<b>59.5</b>	4,812	<b>32.1</b>	<b>91.5</b>
<b>Livingstone</b>	0	<b>0.0</b>	0	<b>0.0</b>	<b>0.0</b>
<b>TOTAL</b>	<b>8,671</b>	<b>578.1</b>	<b>38,151</b>	<b>254.3</b>	<b>832.4</b>

EBAs are trained to prepare and give Oral Re-hydration Salts, to advise on good nutrition for pregnant mothers as well as children, give advice on immunization and the immunization schedule as well as recognize life threatening conditions that need early referral to health centres. In Chibombo, the same EBAs trained as TBAs were trained as Community Growth Monitors and Promoters. They assist the DHMT in the follow-up of children. Some EBAs have demonstrated strong commitment to their work such as the one in Kalomo who cycles 10 kilometres once a week to do growth monitoring and promotion activities at a health post.

EBAs play an important role in the prevention of malaria in their communities and have encouraged their employers and fellow employees to purchase ITNs in their workplaces. They give health education on how to prevent malaria and make referrals to health centres. An employee of one of the lodges in Livingstone obtained a loan from the management of his workplace to purchase ITNs which the surrounding community have bought from him.

### ***FACEAIDS Programme (IR 3.1.5)***

#### **FACEAIDS Status**

The Zambia Partnership on HIV in the Workplace (including ZIHP, ZHECT, ZHABS, Kara Counselling and ZBCA) continues to coordinate efforts in reaching companies using comparative advantages to work together. The Partnership has been meeting to discuss ways to streamline IEC materials of late and is currently working on a treatment brochure.

Three new brochures originating at ZIHP will also join the workplace series along with 8 others already in print. The brochures are being finalized after recent pre-testing was completed. The new brochures cover: condoms myths and misconceptions, care and support to People Living With HIV/AIDS and adult-child communication.

### ***Increased provision of health interventions by traditional healers (IR 3.2.1)***

Traditional healers are a resource in the community. They reach out to a larger population than health centres can. In Zambia 80% of the people see traditional healers before they visit a health centre. Capitalizing on this, ZIHP has supported districts to work with the Traditional Health Practitioner's Association of Zambia (THPAZ) in order to help bridge the gap that existed between traditional healers and health centres.

Through various group-building events the two professions developed somewhat more trust and mutual respect. This led to the development of training materials by the two groups. The materials are used for introducing traditional healers to life-threatening conditions that need referral to health centres. Trained traditional healers continue to send monthly statistics to the health centres on cases seen, health education given, Clorin and ITN sales, condoms distributed and ORS given. Traditional healers are now members of the Neighbourhood Health Committees (NHC) where they contribute effectively to decisions affecting the health of their communities.

In the five districts where the program runs, 1245 traditional healers are registered with 24% oriented in referring high-risk conditions to the health centres. Supervision, as is the case for other community workers, is a major factor to programme success. In this regard, supportive visits have been made to some of the traditional healers and those who were trained last year have received one-week refresher training to re-orient them.

**Table 7: Training data Traditional Healers**

	Registered with THPAZ*	Total number trained till now	Trained in 2003**	Refresher training in 2003
Lundazi	158	59	31	19
Chipata	507	61	36	30
Kasama	70	49		59
Mwense	360	62		56
Samfya	150	68		39
<b>Total</b>	<b>1245</b>	<b>299</b>	<b>67</b>	<b>194</b>

Note: \* 1998 Directory ; \*\* already included in trained till now

Districts involved in the programme have been very supportive and have expressed a need to have more traditional healers join the programme. Lundazi District expanded the program by using its own resources. Other districts have started carrying the costs of the programme themselves: Mwense, Kasama and Samfya contributed each substantially to the costs of accommodation, transport or meals for the participants.

Traditional healers are respected leaders. Thanks to the interaction with the health sector, they effectively reached out to communities with behaviour change messages and they helped to dispel some of the myths and misconceptions about HIV/AIDS transmission. Trained traditional healers are referring cases of STIs to the health centres. Some of the traditional healers are members of home-based care teams and accompany health centre staff when they visit their clients. Traditional healers are now one of the community cadres that distribute condoms for HIV/AIDS/STI prevention. Health centres work with traditional healers to give out preventive messages during World AIDS Day and World TB Day. Last year, Lundazi DHMT held their TB day celebrations at the village of one of the traditional healers.

Traditional healers are mobilizing communities to go for family planning and advocate the need for good antenatal care. They give messages on the benefits of family planning, causes of prolonged labour and dispel myths and cultural beliefs, which discourage people from accessing family planning methods.. With the encouragement from traditional healers more and more women in the districts are using health facilities for antenatal care and delivery.

**Table 8: Traditional healer programme**

District	No. registered traditional healers	No. trained	% of trained
Chibombo	No program		
Kabwe	No program		
Ndola	No program		
Kitwe	No program		
Kasama	70	49	27% (70%)
Chipata	507	61	5% (12%)
Lundazi	158	59	38%
Kalomo	No program		
Mwense	360	62	8% (17%)
Samfya	150	68	17% (45%)
<b>Total</b>	<b>1245</b>	<b>299</b>	<b>24%</b>

With the training they have received, traditional healers can recognize dehydrated children and are referring them to the health centre. They demonstrate the use, and give out ORS as well as sell Clorin for water treatment. Through mobilization by traditional healers, communities have built pit latrines and rubbish pits to avoid diarrhoeal diseases. They assist at the health centres during the Child Health Week to give Vitamin A to children and weigh the children. Some help health centres to carry out under-five activities and give health education on infant and child feeding. DHMTs have requested traditional healers to be trained as community growth monitors and promoters.

*“Traditional Healers command a lot of respect in their communities. This should be capitalized upon. If you visit a traditional healer like Mr. Siliya in Chikomeni, you will find there are more patients admitted at his place than at the health centre. This is why it is very important that all traditional healers are oriented in identifying cases that need referral to health centres. Yes, incorporate them in growth monitoring activities. It is an important starting point. A lot of benefits will come our way if we did this. We need to continue with the traditional healer programme. The DHMT can be assisted in orienting the other traditional healers. The other thing to do is to build capacity in traditional healers by training selected ones to be facilitators.”*

*- Lundazi District Director of Health*

### ***Increase Provision of Preventive and Promotive Health Services by Private Practitioners (IR 3.2.2)***

Private providers play an important role in the delivery of health care services. This is not fully recognized by the health planners. Major advantages cited by the public are: availability of drugs, staff that care, reduced waiting time, more confidentiality etc. Despite this government did not include private providers in training and no efforts are made to collect HMIS type data relevant to this sector.

In collaboration with DHMTs, ZIHP initiated a programme of orienting health workers in private practice to the latest concepts in reproductive health and child health: specific training programmes in IRH and IMCI were implemented.

This year's focus was on following up the trained practitioners and assisting DHMTs in maintaining links with them. One follow up per district and per technical are was executed as planned

### **Integrated Management of Childhood Illnesses**

Fifty three providers out of a total of 99 (54%), from five districts received training in IMCI and have since been followed up. They are able to assess children and refer cases to the hospitals in a timely manner.

Thirty-eight providers representing 38% out of a total of 99 private providers identified in the 12 demonstration districts have been trained in IRH and have been followed up. The trained providers have started implementing infection prevention practices and started to integrate some of their services. With regard to the latter,

clients now receive several distinct services during a single visits. This is a radical departure from former practices.

**Table 9: Private Providers**

Name of district	Number of private providers (2001-2002 data)	Number Trained in	
		IMCI	IRH
Chibombo	4	4	
Kabwe	8		
Ndola	33	18	23
Kitwe	30	13	15
Kasama	2		
Chipata	6	6	
Lundazi	0		
Chama	-		
Kalomo	1		
Livingstone	13	12	
Samfya	2		
Mwense	0		
<b>Total</b>	<b>99</b>	<b>53</b>	<b>38</b>

#### ***Work with Zambia Nurses Association to Monitor and Evaluate Activities in their Strategic Plan (3.4.1)***

The Zambia Nurses Association (ZNA) implements currently the last year of its three year Strategic Plan. Some activities have been implemented, while others are still not done. Some work was done in helping ZNA to monitor activities in its strategic plan. In addition, HIV infection among nurses has been singled out as an activity for which support was requested. ZIHP has assisted ZNA in partnering with HORIZONS to do operations research on workplace programmes in hospital settings. The action research will also rely on ZHECT to implement the FACEAIDS intervention.

Other partners also received support in developing or implementing Strategic Plans: the Medical Council of Zambia had difficulties in mobilising resources for its 2001-2003 Strategic Plan. It was given support in participating better as a key partner of the Sector Wide Approach and was rewarded for its efforts by receiving funding for activities it wanted to embark on.

ZIHP also helped the Zambia Medical Association in developing its 2003-2005 Strategic Plan. This will enable it to carry out activities such as HIV/AIDS prevention among its members.

#### ***Documentation and dissemination (3.1.6; 3.2.4 ;)***

Some of the work done within the private sector needs wide dissemination. The HIV/AIDS Workplace program was documented and disseminated at the Global Health Council in Washington in May 2002. Work with traditional healers has been documented and shared at the Global Health Council meeting of 2003. The Employer Based workplace programme has been documented but not yet disseminated.



### ***Distribution of Social Marketing Products (IR 3.2.4)***

In general, sales of socially marketed products regained their growth during the year. The table below summarizes the trend for brands that are socially marketed by ZIHP. It also includes the sales figures for the commercial ITN brand *Safenite* and the VCT centre *New Start*, which is funded with corporate resources of Population Services International. Although the individual products follow different patterns, it can be said that across brands sales in 2003 benefited from ZIHP's decision to dedicate more human resources to its sales force. Another influencing factor might have been that ZIHP improved the sales incentive scheme which provides stronger performance incentives for the Area Sales Managers.

**Table10: Summary of Sales of Socially Marketed Products**

Product	2000	2001	2002	2003*)	Target 2003	2003 vs. 2002	2003 vs. Target
Maximum	8,365,716	9,959,760	10,106,496	11,745,925	11,500,000	16.2%	2.1%
care	68,112	115,368	253,128	243,680	350,000	-3.7%	-30.4%
New Start			8,156	7,636	7,200	-6.4%	6.1%
SafePlan	432,924	516,960	507,120	694,336	575,000	36.9%	20.8%
Clorin	561,291	1,014,504	1,166,760	1,758,584	1,300,000	50.7%	35.3%
Mama Safenite		11,902	55,402	164,388	145,000	196.7%	13.4%
Safenite	2,059	27,860	69,054	45,587	28,000	-34.0%	62.8%
PowerNet	57,279	42,227	29,433	20,000	20,000	-32.0%	0.0%
Vibrant		77,280	99,300	122,700	150,000	23.6%	-18.2%

\*) 2003 figures are prorated on the basis of the first nine months. This is likely to underestimate the final sales figures since the last quarter sales normally exceed the annual average.

Sales for Maximum were strong due to increased demand, particularly in the more urbanized areas. This trend is related to better coverage of urban areas through mass media campaigns. It is also attributable to larger orders from employers who run HIV awareness programs for their workforce. ZIHP is monitoring these sales closer than sales to commercial outlets, since many of the institutional clients distribute the condoms to the end consumers free of charge, which might leave to wastage and lower usage rates.

In December 2002, ZIHP introduced the 12 pack condoms to the Zambian market. Although orders from the wholesalers were initially high, the package was not very popular among consumers and is now only used for sales to NGOs and some workplaces. Maximum sales could be substantially higher if large numbers of socially marketing condoms had not been brought illegally from Zimbabwe to Zambia. Due to the distortions of the foreign exchange market in Zimbabwe, many products have been smuggled to Zambia such as the Protector Plus condoms. The sales of Protector Plus are conservatively estimated at 1.5 million units in 2003.

Supplies of the female condoms branded *Care* were interrupted by shortages. ZIHP had to turn down larger orders for this product, since the consignments funded by the

German Government were delayed due to extended quality testing of the commodities. ZIHP monitored the stocks so that high priority outlets like bars and night clubs were provided with the female condoms, while customers who were less likely to sell the product to high-risk populations were given only small quantities. Given the limited funding for female condoms and their high cost (approx. \$.67 per unit) this policy is likely to continue over the next years.

ZIHP recently signed a Memorandum of Understanding with the National Malaria Control Centre to formalize public sector relationships with the Central Board of Health. Shortly after this significant achievement, DFID granted a \$2.4 million contribution towards the promotion of Mama Safenite. With 110,000 units sold in the current year, Mama Safenite contributes substantially to Zambia's commitment to reaching the Abuja target of 60% household coverage with ITNs.

In addition to Mama Safenite, ZIHP continues to market Powernet, which is a re-treatable ITN. Distribution of Powernet is restricted to four districts where the net is sold to the general public at price of K10,000. The Powernet program is struggling with low re-treatment rates, heavy project management costs, and insufficient ownership by the participating districts and NMCC. Given these constraints, and insufficient commodities funding to sustain untargeted sales with any kind of consistent supply, ZIHP plans to merge the Powernet program into the Mama Safenite operations in the first quarter of 2004.

To satisfy the latent demand for ITNs, ZIHP started the distribution of long lasting mosquito nets in late 2000. This activity is not financially supported by USAID or other donors, so the Safenite commercial price must cover the commodity cost plus a mark up for distribution, admin and overhead costs. The demand for Safenite remains stagnant, due to low consumer purchasing power, market saturation for the demand that does exist at full commercial prices, and increased competition. Sales in 2003 were driven by UNICEF for distribution in Southern Province under a drought relief program.

Despite the difficulties of promoting commercial sales, ZIHP continues to support Safenite as the longer-lasting ITN technology, and in anticipation of a growing net culture over time behind increased funding and consistent supply for subsidized distribution to vulnerable populations. ZIHP entered into a commercial partnership with Vestergaard Frandsen in early 2002 to begin co-branding Safenite as "the Permanent™ treated net".

#### **Partnership with Coca-Cola**

In October 2002 ZIHP met with representatives from Zambian Bottlers (ZB) who are distributing Coca-Cola and other soft drinks in Zambia. ZIHP requested support in the distribution of socially marketed products, particularly of Maximum condoms. Zambian Bottlers agreed to distribute Maximum through the so-called "containers". These containers work as wholesale outlets to the small kiosks widely known as Ntemba stores which sell soft-drinks and other fast moving goods in convenient locations in compounds and residential neighbourhoods throughout Lusaka. There are 200 Ntemba stores and 50 'containers' in Lusaka.

By the end of the reporting period ZIHP sold Maximum to about 60% of the “containers”, however, this approach has not proven to be sufficient to move condoms to the Ntemba stores. For this reason ZIHP dedicated one person to distribute condoms from the containers to the Ntemba stores. About 23,000 condoms have been sold into Ntembas over four months through this mechanism. While this is for ZIHP a high cost distribution mechanism, it also offers substantial health impact, since most of the Ntembas are in low-income neighbourhoods and are open until late at night, so that they provide excellent outlets for targeted social marketing. In addition, Zambian Bottlers has allowed ZIHP to join their staff in the sales trips to bars and night clubs, which are also critical outlets to target people who engage in sex with high risk of HIV/AIDS transmission.

#### **Water Kiosks**

Water Kiosk partnerships have the potential to increase the access of many small neighbourhoods to ZIHP health products. ZIHP has recently piloted a partnership in Monze with the Sanitation and Water Supply Committee to include Budizas, Clorin, ITNs, male and female condoms in the water kiosks which are often frequented by women from the neighbourhoods. Preliminary results indicate that sales of ZIHP products are brisk and encourage the kiosk vendors to stay open later as their revenue increases.

### **C. Implications**

#### **Social Marketing**

Training of health centre staff is crucial for the promotion of products like oral contraceptives, ITNs and vitamin supplements. ZIHP will have to combine its efforts across socially marketed brands to keep these training sessions cost-effective. The ongoing integrated activities of provider training for oral contraception and promotion of ITNs and Clorin show that there is a lot of interest at the DHMTs for such integrated training workshops.

The Coca-Cola partnership bears a great potential to reach a large number of outlets in low income areas. If this partnership is successful in Lusaka, it should be replicated in other urban areas in Zambia. However, the distribution cost experienced so far puts still a question mark whether such scale up is financially viable.

#### **Refresher training of Supervisors of EBAs**

DHMTs show that they can take on more active roles in the supervision of the EBAs and other cadres. They should hold regular refresher trainings for their staff and allocate resources to the programme. Much still needs to be done to create that sense of awareness and ownership.

#### **Training for EBAs**

There is a continuing demand for training EBAs in rural communities as Community Health Workers. As seen in some districts already, the broader skills base will enable them to carry out more activities and to be able to treat minor ailments in communities. DHMTs should welcome those candidates for CHW training.

The demand also comes from a the reduction (sometimes by 50%) of trained EBAs to death, retrenchments or transfers. It affects work and this can be seen from the CYP data.

#### **Increased provision of preventive and promotive health activities by traditional healers**

DHMTs have embraced this programme very well, but it remains still a new programme. Trained traditional healers require a lot of support, and resources for this compete with those to train others. The DHMTs have still to find the best ways to supervise traditional healers.

#### **Expansion of FACEAIDS programme**

ZHECT has done extremely well for its first year. Demand for workplace programmes is increasing and new demands emerge. ZIHP has to pay attention to this changing environment.

### ***D. Challenges***

1. Selling meaningful numbers of ITNs without any subsidy is becoming increasing difficult. This may be the result of a saturation of the commercial market, but could also be related to the distribution of subsidized nets.
2. The rate at which EBAs are leaving employment is high: death, retrenchment or transfers. The absence of debate on the merit of these agents makes this strategy extremely dependent on projects like ZIHP There is a challenge to try to capture the attention of MoH, CBoH and partners.
3. Many traditional healers are illiterate. The training model used by ZIHP (adult learning or participatory learning) puts a selection pressure on the target trainees. There is need to explore other methods.
4. The challenge of collecting data has yet to be addressed: *“Private health providers have never been interested in producing data. Now that they have been trained and followed up, the challenge is to get DHMTs to maintain the interest in the private providers and to support them. Private providers hardly send any reports to the DHMTs. Their activities are not reflected in the districts reports.”*

### ***E. Modifications***

1. ZIHP will spend more resources on training of RHC staff to use increasingly public sector facilities as outlets in rural area.

## **IR4: Improved Health Worker performance in delivery of PHN Interventions**

### ***A. Approach***

Several institutions are key in ensuring improved health workers performance. Central Board of Health and the different DHMTs manage and supervise the different health workers. The Medical Council of Zambia and the General Nursing Council regulate the profession and set the standards of education and practice.

ZIHP's intervention strategy is to support, with all partners available, the implementation of national plans that are designed to strengthen the different systems that ensure high performance of the health workers. The support consists of technical and financial resources to build strong capacities in pre-service and in-service training.

Some of those investments are directed towards strengthened monitoring and evaluation of standards in education and in clinical practice and towards support to development and testing of sustainable approaches for human resources development in the 12 districts targeted by ZIHP.

### ***B. Accomplishments***

#### ***Develop systems for monitoring the quality of service delivery (4.1.1) and the quality of nursing education (4.1.2.)***

In 2002, the General Nursing Council (GNC) started surveying 15 sentinel sites in order to monitor the quality of services delivered by nurses. The major success for the reporting period was the completion of data collection for the 15 sites and the comprehensive analysis of data. The average score of the 80 departments inspected was 62% in terms of the availability of infection prevention guidelines, equipment and supplies. On the other hand, the average score of the 121 nurses observed in practice was 54% in terms of performance in infection prevention practices.

#### **Main Results from the sentinel survey**

<b>12 Competency Areas</b>	<b>Mean Scores %</b>
Injections	69
Client Admission	66
Nursing procedures	63
Care of Febrile Clients	60
Infection prevention (Facility)	62
Infection prevention (Observation)	54
Drug Administration	51
Client assessment	50
Emergency Care	47
Nurse – Client Interaction	43
Record Keeping	42
Health education	31
Use of Nursing Plan	26

Note : total number of observations is not identical throughout all areas

These results revealed that there is a system wide problem of health institutions not providing health personnel with adequate equipment and supplies for them to carry out their duties adequately. While the nurses performed well in the use of injections and client admission they performed poorly in the initiation of the nursing care plan, health education and record keeping. The absence of the nursing care plan in the clients records also affected the score rating for record keeping.

It was clear from the findings that on average nurses' activities in the health facilities do not form part of the client assessment records. This situation undermines the contribution that nurses put in the whole process of client admission and assessment. The performance in health education clearly revealed that nurses do not take advantage of opportunities to provide health education to clients.

The results point to the need to strengthen all competency areas. GNC will use these and other results to make decisions on how to improve the quality of nursing education.

The results were presented at the American Public Health Association Meeting in November 2002. In addition, GNC held a national dissemination of these results in June 2003, and received valued feedback from various stake holders. Recommendations included that data collection be carried out only every two years. As a follow on activity, capacity building of staff at GNC has continued: building skills in data collection, analysis and dissemination.

While the sentinel survey successfully tracked the performance in the facilities, monitoring data on educational standards of nursing in the training institutions were still not collected. A Steering Committee developed a data collection plan for the training institutions. These data will provide important baseline indicators for future comparison. This is of particular importance with regard to monitoring of the new curriculum.

#### ***Improved quality of education and training (IR 4.1.3) and adaptation of Institutions to the new Scope of Practice (4.1.4)***

In 2002, GNC received ZIHP support for developing a Strategic Plan for Training Institutions. It has been a key document for the mobilization of resources: the Africa Development Bank, the Danish International Development Agency, the World Health Organization and USAID funded projects like ZIHP and JHPIEGO have based their funding on the requirements formulated in the plan.

Support from ZIHP was instrumental in allowing GNC to introduce the Professional Regulatory Framework in the national debate about standards. This regionally developed framework of nursing standards has helped Zambia in designing a draft set of standards applicable in the national context. Support was also provided to the orientation and training of tutors of all training institutions who will have to incorporate those standards in their training and education practice.

In addition, the newly released Scope of Practice requires training institutions to adapt to requirements for new skills amongst nurses and midwives. Therefore, support has been provided this year to the organization of orientation workshops for tutors, that take on board managerial and technical issues in the new curricula : infection prevention, malaria during pregnancy, financial and administrative systems, health information systems planning within partnership contexts.

Lastly, against a background of strong political pressure, GNC needed to assist training institutions in meeting a July 2003 deadline imposed by parliament: training institutions were expected to double their current intake and to implement revised curricula by that period. ZIHP provided support to GNC in organizing the preparedness of the different institutions.

#### ***Support to Revision of Curricula (4.1.5.)***

Several curricula required completion of their review. Special efforts have therefore been made to ensure proper and timely revision and validation of those curricula. Support also went to the subsequent development of adapted learning materials. With this assistance, GNC and CBoH were able to organize the review of the curricula of the Zambian Enrolled Nurses and the Registered Mental Nurses.

Although much still needs to be done, training institutions have proven by this that they can adapt the institutional capabilities for pre-service training rather quickly to a changing external environment.

During this reporting period, meetings were also facilitated to update the different tutors to the revised curricula: 30 tutors in the Enrolled Nursing Schools, 45 tutors in the Registered Nursing Schools and 5 tutors in the Registered Mental Nursing Schools.

#### ***Support CBoH in strengthening capacities of ICT in-service training teams at the provinces (4.2.1)***

Zambia has invested heavily in designing and testing training programs to upgrade the competency of nurses, clinical officers and environmental health technicians to a level compatible with the requirements formulated in conjunction with the Basic Health Care Package. One of the outcomes of this process is the establishment of in-service training systems at province and district levels.

These in-service training systems at the provincial and district level are now functional. By the end of 2002, nine provincial training sites had conducted each, an average of two sessions. During 2003, the nine sites succeeded conducted each at

least another session. This translates into over 600 health workers who received integrated competency based training in 2002, and an additional 180 in 2003..

Although challenges exist which affect the quality of the training, e.g. adequacy of training materials, transport problems and late release of funds by smaller districts, the preliminary results of evaluations show an increased confidence gained by the graduates in providing quality services to community members. The process for documenting the experiences and lessons learned in the establishment of the training system has started.

***Improved in-service training for skills that relate to different technical areas (4.2.4 till 4.2.12; 4.2.5)***

The health reforms have provided Zambia with a strong conceptual framework for managing the different public health interventions and their linkages in a comprehensive and integrated manner. The Zambian Basic Health Care Package is therefore the ultimate reference for understanding ZIHP's contribution to skills development through the support to individual technical areas.

Different districts received specific support for sustaining the improvement of health worker performance. Training needs of facility level health workers were identified in Chipata. Findings included: low compliance with good infection prevention practice guidelines and inadequate utilisation of partograms. The outcome of this assessment triggered an intense debate on the limited use of training or retraining unless performance was addressed in a larger context that included also supervision. The overall approach towards refresher training for health workers was subsequently redefined.

ZIHP then provided technical and financial support to five districts, Samfya, Mwenze, Ndola, Livingstone and Kitwe, in conducting supportive supervision to health centres. Efforts concentrated on helping district supervisors conducting effective supervision by observing health workers during the provision of IRH services. Most of the health workers observed showed improved skills in the provision of antenatal services, such as routine examinations and investigations, and in the use of partograms. Infection prevention practices were greatly improved in health facilities where trained health workers had also access to JIK and infection prevention equipment. Areas requiring improvement include the provision of information to clients on VCT, the use of ITNs and the use of Fansidar for malaria prevention during pregnancy.

In addition, ZIHP provided support to Kitwe DHMT in conducting the post training follow-up visit to 24 health workers. The 24 health workers, who came from 24 different health centres in the district, were visited each in their post. Findings included improved family planning counselling using the Family Planning Counselling Kit, and a marked increase in the method mix. Out of 24 health centres, DHMT supervisors found in 21 cases that infection practices improved, including better display of Infection Prevention Guidelines and a better display also of supplies. This follow up visit also revealed that that integration of services will remain a challenge, especially in the smaller health centres that have few staff.



ZIHP has continued to make major contributions to the capacity of CBoH to nation wide scale up of post abortion care. Continued support was provided to the establishment of training and service delivery sites for post abortion care in nine provinces, each with a core team of 5 medical officers and 3 nurses. ZIHP helped in building the capacity of the PAC core teams in infection prevention, contraceptive technology, manual vacuum aspiration. In addition, core teams members received support in developing teaching skills. .

Finally, in two provinces, 8 Medical Officers and 6 Nurses have been trained as PAC clinical trainers. This forms a core team of trainers who will ensure the sustainable scale up of PAC services in their respective districts and health centres.

Future support will include the establishment of a monitoring and evaluation mechanism and the documentation of experiences and lessons learned.

ZIHP continued to provide technical and financial support to CBoH and DHMTs in the continuous improvement of IMCI planning and implementation: finalisation of the adaptation of IMCI training modules to disease patterns influenced by HIV/AIDS, and to the revised malaria drug policy, development of strategies for inclusion of IMCI in pre-service training, development of strategies to further increase implementation of IMCI at the community level.

This year, a further 25 health workers were trained in the standard IMCI course, and another 10 people were trained as facilitators. The total figure of health workers trained with direct support of ZIHP is now 699. The 12 demonstration districts have received the largest share of this support (528 out of 699).

This figure represents also a coverage rate of 68 % of health workers initially identified for training in the 12 districts. It translates into a rate of 2 health workers per health centre, trained in IMCI. This is the target rate that WHO recommends for achieving IMCI impact.

Since the early nineties, the update of knowledge and skills of health workers with regard to EPI has been a concern. Zambia succeeded in attracting funding from GAVI. CBoH has now developed strategies to improve the routine immunization, to introduce new and under utilised vaccines, and to improve infection safety practices. ZIHP provided strong technical support to this process and helped CBoH embark on a national orientation program on EPI and immunization practices. Technical and financial support was also provided to the conduction of a workshop for EPI Master Trainers. The outputs of this are the availability of 35 health workers, from national and provincial level. Furthermore, as a contribution to the national programme of building new capacities in EPI training, ZIHP gave support to Southern Province and Central Province in training 58 district officers as EPI trainers.

### ***Support CBoH in training PHO and DHMTs in technical supervision (4.3.1)***

A ZIHP wide effort to support CBoH in rationalizing the implementation framework of quality improvement is described under improved policies, planning and support systems. Since this requires also better internal ZIHP coordination, efforts have been made to harmonize the technical and financial support offered to DHMTs.

During the reporting period, visits to districts have incorporated the preliminary recommendations regarding facilitation, coaching and supervision techniques. Based on the few field trips, it is anticipated that real progress will be reported in the next period. Implications on training needs assessments are already obvious. Training will be driven by observation of gaps in performance rather than being driven by supply.

### ***C. Implications***

#### **With regard to ICT Training**

Decentralization of the ICT training has created greater demands on ZIHP with requests coming from all provinces. In order for ICT to be sustainable, ZIHP has to prove that results can be achieved within a resource context that is radically different from that of the design and testing stage.

ICT will also have to undergo the critical examination of its effectiveness in operational conditions. It is anticipated that the supervision debate will influence the ICT implementation strategy.

Health worker skills in assessing malnutrition, in diagnosing anaemia or in providing counselling to caretakers remained low during follow up visits. ZIHP has to consider on how to help DHMT staff feel familiar with on the job refresher training for health workers. This calls for even stronger efforts to find appropriate ways of strengthening supportive supervision.

### ***D. Challenges***

1. ICT continues to face big challenges in funding. There are concerns that the duration of training for district health centre staff is too long- that health workers are away from the station for too long in the light of inadequate human resources in the health facilities.
2. The implementation of separate financial accounting system for training institutions calls for the need to strengthen the linkages between DHMTs, hospitals and the provincial health offices as full implementation of the TI work plans will depend on income generating activities with DHMTs.

**E. Modifications.**

1. Several activities in support of pre- service training, in-service training and supervision had to be cancelled due to budget restrictions during quarter one of 2003. It will not be possible to catch up with the intense agenda that was planned for 2003. Further budget restrictions during the second quarter will put further strain on the implementation of the work plan.
2. **Florence Nightingale Information System**  
With the initial installation of the system by JSI Project where there was no ownership by GNC, the system was left to breakdown. Efforts by ZIHP to revive it have failed because the soft ware and hard ware are non functional.
3. **GNC financial sustainability**  
A consultant was contracted by ZIHP to do a financial analysis of GNC to do a financial analysis of GNC. Results of the report were not accepted due to lack of transparency by GNC on other sources of income from other partners and within GNC.
4. **GNC /M & E Strategy**  
From the original GNC M & E strategy this was supposed to be frequent monitoring of the reporting rates of the sentinel surveillance system. Based on the experiences of implementation, and taking ;into consideration the financial and human resource capacity of GNC, it was recommended that the surveillance be done on intervals of 2 – 3 years apart.
5. Strengthening TIs to coordinate in-service training initiatives.
6. **Strategy for strengthening the Integration of STI/HIV/AIDS into MCH/FP and OPD services and Support development of syndromic management**  
Implementation of these two activities depends on the National STI/HIV/AIDS Task Force development of STI syndromic management protocols. The process of STI syndromic management protocol development seems to be taking long with CDC still at the stage of developing strategy for conducting survey. Therefore, given ZIHP time frame the two activities above will have to be cancelled.

TOT computer assisted clinical training skills in PAC. Since the activity was being planned to be done in collaboration with other partners, general consensus has not been reached yet on when this activity can happen.,

## **IR5: Improved Policies, Planning and Support Systems for the delivery of PHN Interventions**

### *A. Approach*

The activities that fall under this section build on the experience gained during the first four years of the Programme. ZIHP works very closely with counterparts in the Ministry of Health and in the Central Board of Health. The programme engages counterparts and stakeholders in approaches that stress the supportive role of the central and intermediate levels in the system.

Fully in line with the logic of the programme, planned activities target people-level impact in the twelve demonstration districts, yet never exclusively in those twelve districts. Often, like in the previous years, more districts will directly benefit from the programme and for certain interventions, all districts will be involved.

Activities effectively contribute to the environment that communities need in order to make greater use of health interventions which include improved policies, planning and support systems. ZIHP makes use of lessons learned from work with communities, from experiences gained while working with different health services, and from private sector partners.

### *B. Accomplishments*

#### ***Establish Policy Agenda and Update it on Annual Basis (IR 5.1.1)***

Policy advisory services that have been provided by ZIHP have significantly contributed to the enhancement of policy management at the MoH and policy implementation at the CBoH. It is, however, also true that a lot remains to be accomplished in terms of honing policy formulation, implementation, monitoring and evaluation skills at the Ministry. There are, for instance, deficiencies in policy coordination, inordinate delays in policy implementation, including inadequate skills for monitoring and evaluation of the implementation of approved Cabinet policy decisions. To a degree, ZIHP has been hampered given the high staff turn-over that has impeded the development of a sustainable pool of policy relevant personnel at the MoH.

In an effort to continuously enhance policy management, the restructured MoH has now a specific directorate responsible for policy development, monitoring and evaluation. There are altogether 10 policy analysts and a director in charge of the unit. The priority of ZIHP's technical assistance during the review period was, therefore, towards capacity building. A one-week policy capacity building workshop was organised for new directorate. Nineteen MoH technical staff from the Directorate of Health Policy and other Directorates attended the workshop. Prior to the formation of the Directorate of Policy, policy development was handled by staff in the budget office who took it on as an additional (if not peripheral) function. Since the inception of ZIHP in 1999, there has been a noticeable improvement in policy management as a result of its advisory services.

Over the period, for instance, ZIHP has organised targeted policy workshops for staff of the MoH, CBoH, the University Teaching Hospital (UTH) and other related institutions with staff from the Policy Analysis and Coordination Division of the Cabinet Office participating as instructors. Technical Assistance was further provided to technical working groups on policy. This included drafting of the Human Resources Policy, Health Policy for the Catholic Church, editing of the National Health Care Financing Policy, including the Preventive Maintenance Policy and the Integrated Reproductive Health Policy.

***Topical Analysis Based on HMIS Products Developed for Discussion (IR 5.1.2)***

The restructuring of the MoH and recruitment of a good proportion of new members of staff necessitated an induction workshop with emphasis on health reform objectives and principles. ZIHP provided technical assistance towards conceptualisation as well as facilitation of the workshop. Altogether, 73 members of staff (about 90% of the MoH establishment) attended the 2-day workshop.

Linked to this workshop was also the development of a brief document outlining the roles and functions of MoH, performance indicators for the MoH directorates and suggestions on frequency of reporting on agreed indicators.

***Policies and Approaches for Expanded Community Level Delivery of the Basic Health Care Package (BHCP) Clarified, Debated and Disseminated (IR 5.1.3)***

**Support and Learning Teams (SALT)**

ZIHP has continued to support capacity building at community level through its participation in the National Facilitation Team (NFT). The NFT which has been endorsed by the National AIDS Council, coordinates capacity building activities through smaller units called Support and Learning Teams (SALT). In addition to encouraging local organizations to facilitate local responses rather than dictate them, the SALT teams are also catalysts in the establishment of District Facilitation Teams. The DFTs comprise local stakeholders who take on the responsibilities of networking with other districts, knowledge transfer and learning from action and facilitation.

During the year under review, the SALT team made visits to Mongu, Mkushi, Mpika and Kitwe to attend workshops initiated and coordinated by respective DFTs. For each workshop, an average of 50 participants conducted field visits to learn how people in communities affected by HIV are coping. Participants then mapped their resources and collective strengths by creating a plan of action. As this process develops, an emerging challenge has been to change the community's perception that the NFT is available to them at anytime for supportive services. The aim of the SALT team is, rather, to only initiate the process which should be taken over by respective communities after each introductory workshop.

### **Policy Briefs Capacity Building Workshop**

The workshops had focussed on imparting skills related to policy formulation, implementation, monitoring and evaluation, including data collection and processing skills in support of policy management. The Programme has also made significant contributions to the understanding and appreciation of policy interfaces between and among line Ministries. This is especially in regard to the inter-ministerial consultative process, the role of Inter-Ministerial Committee of Officials (IMCOs), liaison with PAC at the Cabinet Office, solicitation of Treasury Authority, including how Cabinet business is organised and conducted. Policy implementation plans are now a requirement not only because of their facilitation of monitoring and evaluation but also because they enhance accountability and responsibility on the part of implementing officers.

Another capacity building workshop was conducted for policy analysts in the Directorate of Health Policy, MoH by ZIHP. The three-day workshop focused on the development and importance of briefs, formulation formats and drafting of policy documents. Each policy analyst has since been working on a specific topic for a policy brief and most of the briefs have been completed. Meanwhile, ZIHP will continue to provide support to individual policy analysts to enable them to successfully complete and disseminate policy their work.

### ***Policies and Approaches for Expanded NGO Involvement Clarified, Debated and Disseminated (IR 5.1.5)***

Society for Women Against AIDS in Zambia, Kara Counselling Trust, the Traditional Healers and Practitioners Association of Zambia, Network of Zambian People Living with HIV and ZIHP continued to facilitate and provide funding for district level workshops on community responses against HIV/AIDS and the development of requisite local capacity. During the period under review, two workshops were conducted in Mongu and Mkushi districts with a total of 58 participants who included government officials, NGOs, traditional leaders, churches, private sector, women and youth groups.

These workshops and field visits were intended to engender a paradigm shift to one that emphasizes local capacities, intra-community transfer of knowledge and concepts with the Support And Learning Team (SALT) providing facilitation rather than adopting the role of implementers.

### **Role of Traditional Leaders in the Fight against HIV/AIDS**

The role of traditional institutions in the fight against HIV/AIDS has often been recognized. However, there are currently no concrete programmes at national level for addressing this issue in a systematic way. An initiative comprising the USAID, the Ministry of Local Government and Housing (Department of Chiefs' Affairs), the National Royal Foundation, DfID, UNDP and ZIHP has begun preparatory work on this issue.

During the past six months, ZIHP has been offering technical support to the Traditional Leaders Initiative(TLI). Targeting effective interventions in rural areas has, however,

been difficult and, consequently, ZIHP has been working with the Royal Foundation (RF) that comprises 14 members in engaging chiefs and headmen in HIV/AIDS advocacy, social mobilization and sensitization. As respected members of the community, traditional leaders have been a useful resource in community action that has either been under-utilized or completely neglected.

ZIHP formalized its relationship with the Royal Foundation through an introductory workshop that was officiated by Hon. Sylvia Masebo, M.P., Minister of Local Government and Housing. The workshop was a milestone in the sense that it was the first of its nature. It specifically targeted traditional leaders and was the first product of a collaborative relationship between the Ministry of Local Government and Housing and the health sector. The out come of the conference led to consensus building about the objectives and vision for traditional leaders' response to HIV. The following are some of the resolutions that were agreed during the workshop:

- As individuals with the power to change customary law, chiefs agreed to stop the practice of widow inheritance and sexual cleansing;
- Chiefs will obligate all NGOs working in their chiefdoms to consult traditional leaders prior to implementing any programmes; and
- Traditional leaders will lobby for their involvement in District Development Coordinating Committees.

As the way forward, the Executive Committee of the National Royal Foundation will pilot programmes in their respective areas with funding of K13, 000, 000 each. To date, proposals from six to seven chiefdoms have been received, while introductory workshops have been held. The lessons learnt and experiences gained in each chiefdom from implementation of the pilots will be shared in a national workshop scheduled for 24 to 26 November 2003 that will attract participation from 110 traditional leaders throughout the country.

*"We will give our full commitment to this fight against HIV. We shall not give up and we will not fail our people by standing by idly"*

*- Senior Chief Nalubamba*



The Traditional Leaders Initiative has, on its part, proved to be a good opportunity for collaborative initiatives with other bilateral and multilateral agencies such as DfID, JICA and UNDP who have brought additional funding and technical support to leverage the resources committed so far. As a result, an office for the Royal Foundation has been established and renovated at the Civic Centre.

## **SWAP Management**

ZIHP continued to provide support to MoH and CBoH on SWAP management. The support included technical assistance towards preparations for the bi-annual consultative and health sector committee meetings, participation in several SWAP committees (resource allocation, hospital reform, monitoring and evaluation, etc). Conceptualisation, provision of logistics, funding for meetings and key discussions were also significant technical backstopping services that ZIHP provided.

### ***Increased Capacities of DHMTs in Planning (IR 5.2.1)***

The decentralisation of planning and peer to peer dynamics of review and support have created a pool of know how that CBoH has learned to tap into. In close collaboration with CBoH, ZIHP continued therefore, to provide technical support to provinces and districts during planning cycles.

### ***Increased Planning Skills of Technical Personal in Districts (IR 5.2.2)***

ZIHP has continued to give technical support through the government structures at central, provincial and district levels. During the first half of this year, the focus was to support CBoH in preparing for the annual review of the planning cycle in the 9 provinces and the centre. Outcomes of the annual review of action plans for 2003 also assisted CBoH in preparing for the launch of the 2003 planning cycle. The review of the action plans also assisted CBoH to produce guidelines for the 2004 planning cycle.

### ***Increased skills of Management and Administrative Staff in Financial Management (IR 5.2.3)***

ZIHP collaborated with the CBoH to design a training package in financial management, which will be used to train non-accountant staff. It is planned that this course will form the financial management component of the new diploma course for District Managers.

During the first and second quarter of the fiscal year under review, ZIHP has supported five workshops financially in North-Western, Copperbelt, Southern and Northern provinces in the roll- out of the Financial Management course to their districts and hospitals. ZIHP support continues in 21 Districts of Southern and Copperbelt provinces and extends to all Provincial Health Directors and CBoH Directors. There were delays in support to Northern and North-western provinces as a result of setbacks in funds mobilisation for the courses. The CBoH is now trying to mobilise resources for the remaining 52 Districts from other partners.

As part of the ongoing plans of CBoH to provide training institutions with independent budgets, planning and budgeting by training institutions has received increased attention. In partnership with WHO, ZIHP provided support to CBOH and GNC in developing cost estimates for different aspects of the running of training institutions. This information



will be used by CBoH, as part of general efforts to improve resource allocation in the health sector. The Cost Estimate Study has now been completed. It gives an estimate of the funding requirements per student, depending on the type of training

***Provincial Offices Strengthened to Support Improvement in District Action Plans (IR 5.2.4)***

Supervision is key to improving the standards of quality of health care services. To respond to this great need, ZIHP supported 3 officers from CBoH, Central and Southern Province to travel to Eastern Province to assist the Provincial Health Office during their Annual Action review meeting and Performance Assessment activities. The purpose of the activity was to strengthen the capacity of the Eastern Provincial Health office in both planning and supervision.

***Planning Guidelines Refined, Disseminated and Applied (IR 5.2.5)***

The Planning Handbooks, produced in 2000 are in their third year of use. They provide all districts with a stable set of guidelines and procedures for district level planning. The enormous demand for the handbooks requires production of new editions each year and each edition is an opportunity to improve the presentation.

The continuous refinement of the handbooks, dissemination and application in all health centres, districts, and hospitals exerts an upward pressure on national level planners. It helps in ensuring that the increasing number of global initiatives become fully integrated in the existing district level planning system.

CBoH management, was also interested in improving its internal planning and thus invited ZIHP to assist in designing steps that built on successful processes used in the district level planning. This led to the production of a planning handbook for CBoH management, specialists and partners. The Handbook reflects again the input and ownership of the directors, specialists and province teams involved.

A major success following the establishment of the national task force on infection prevention has been the finalization by this task force of the guidelines in 2003. They formed the basis for orienting health workers to improved infection prevention practices. Through this, ZIHP has contributed with other partners to CBoH's capacity to orient policy makers, to disseminate the technical information to wide audiences and to train provincial trainers in Infection Prevention.

***District Plans and Budgets Reflect Progressively All Resource Transfers (IR 5.2.6)***

CBoH Planners and Financial Managers are known for their rapid response to requests for more and better information from co-operating partners in the Basket Steering Committee. While criteria for grant allocation have remained unchanged since their first introduction, district resources remain varied. Districts nevertheless improve in their ability to reflect all resource transfers in plans and budgets. The best indicator for such

progress is the appearance of truly consolidated budgets at Provincial level, monitored by the Basket Steering Committee.

Although results are relatively tenuous, MoH, CBoH and NAC succeeded in framing programming and planning policies so that the basket and the package approach remain key concepts throughout the continuous adaptation of existing systems to the growing mix of external global resources: GAVI, GAIN, Global Fund, HIPC and RBM. ZIHP has provided strong technical support to specialists at different levels and in different institutions.

### ***Provide Support to the Steering Committee to Implement the NDP (IR 5.3.1)***

As a member of the Core Technical Committee of the National Drug Policy (NDP), ZIHP continues to provide technical assistance to this Committee. Other collaborating partners include WHO, Sida, UNFPA and MSH. ZIHP supported and provided technical assistance to a retreat held mid-year, where the stakeholders including the University of Zambia, MoH, CBoH, Pharmacy & Poisons Board, Private Pharmaceutical Manufacturers and Ministry of Community Development and Social Services developed and presented their Draft Implementation Work Plan according to the key intent areas of the NDP. This output is expected to form the Draft Implementation Work plan of the National Drug Policy agenda.

Regular meetings of both the Core Technical Committee and the Quarterly Expanded Committee have been held during the year. During this period, in a bid to improve the quality of commodities moving in the market, a position paper on the constraints/potential of the National Drug Laboratory as an alternative to the National Drug Laboratory Control was also presented to the National Drug Policy Steering Committee (NDPSC). In response to reports of increasing sub-standard drugs on the market, the NDPSC reviewed and adapted the WHO guidelines for donated drugs, to suit the Zambian environment. In addition, the WHO Certification Scheme in force for products moving in international commerce, was circulated to all stakeholders, including the Office of the President, as guidance on standards for quality of donated drugs.

Upon request from CBoH, ZIHP provided technical assistance to a paper submitted to State House (through the Investment Centre) on investment opportunities in the Pharmaceutical Sector in Zambia.

### ***DILSAT Tested, Revised and Progressively Applied Nationwide (IR 5.3.2.)***

For the past two years, ZIHP has been collaborating with CBoH to explore different ways of implementing DILSAT, focusing on the change that such a tool should stimulate. After the successful application of the customised tool in Kafue, the tool was further revised. Initially, applications of customised DILSAT was demand-driven, and 5 Districts were covered. Another innovative approach of DILSAT application was used through on-the-job training initially by the Central level and later through the Kafue DHMT team. This

approach has shown that the one-on-one training environment does foster a more cordial relationship between trainer and trainee. As a result of this approach, 3 of the 5 Districts have gone further and trained their Health Centres.

After the first Kafue DHMT Exchange Forum Workshop, another DILSAT Exchange Forum Workshop was conducted in Ndola, in April this year, for 10 Districts from the Copperbelt and Central Provinces.

During the same period, 3 Districts in Eastern Province had on-the-job training in DILSAT, conducted by fellow health professionals from Ndola and Lusaka DHMTs as well as from Western Province Provincial Health Office. In June this year, 3 Districts from Luapula, and Northern Provinces came to learn experiences as well as skills building in application of DILSAT at Kafue DHMT. A follow-up visit to Eastern Province to monitor progress is due later this month.

ZIHP's strategy in all these training approaches, has been that all participants from a particular District/Hospital develop an Action Plan at the end of the Workshop. These plans include debriefing of management in the purpose/benefits of applying DILSAT, and dissemination of acquired skills in logistics systems and self-assessment to peers and subordinates through on-the-job training and/or workshops.

This approach has necessitated technical back-up support to the Districts, for effective implementation of plans, creating demand for expansion of the original Kafue DHMT team of trainers. Consequently, ZIHP in collaboration with CBoH have further built capacity in health professionals from Mongu Provincial Health Office, Chibombo, Ndola, Livingstone, and Lusaka District. These health professionals have been empowered as resource persons for the DILSAT inter-District Information Sharing Exchange Forum peer to peer training.

Subsequent monitoring and evaluation by the Central level and the team, have shown significant improvements in logistics management systems in most of the Districts that have benefited from these trainings. DILSAT has now been recommended to be used as a complementary tool to the Performance Assessment.

Other benefits of these approaches, have been evident with the second module of DILSAT applied through peer-to-peer exchanges between Kafue/Chibombo DHMT facilitation to Livingstone and Kalomo DHMTs with technical and financial support from ZIHP.

#### A Patient's - Story

Patients can attest to the availability of drugs at health facilities dotted around Kafue. Enala Ngulube of Soloboni compound expressed her appreciation of the change when she visited Kafue Estates Government clinic:

" Before, they would ask you to buy your own drugs because they didn't have any in stock. I was given all the drugs the doctor prescribed for my complaints. This would not happen in the past," said Mrs Ngulube.

In mid-March this year, ZIHP in collaboration with DfID and CBoH, organised and conducted an Orientation Workshop for the newly recruited Provincial and Hospital Pharmacists. The objectives of the orientation, apart from DILSAT training, was meant to, acquaint the newly recruited Pharmacists with: the MoH structure and its departments, the National Health Reforms, skills building in drugs and medical supplies logistics and laws governing pharmaceutical practice. This Workshop was followed by a Training of Trainers, to build capacity in the team, as they are focal persons in spearheading nationwide training of all Districts and Hospitals in DILSAT/Logistics Management Systems.

ZIHP provided financial and logistical support to the printing and dissemination of all DILSAT materials for self assessment, to all the Provinces, Districts, Hospitals and Health Centres. The dissemination was done in partnership with Medical Stores Limited, whose distribution network covers all Districts and Hospitals in Zambia.

In response to a request from CBoH/MoH, ZIHP is providing in-put to a concept paper on 'the DILSAT Experience in Zambia' to be presented by the Minister of Health, at an International Conference in Tanzania.

### ***Personnel at All Levels Trained in Logistics (IR 5.3.3)***

After the design of the standard Requisition for Drugs and Medical Supplies form, by ZIHP supported and funded an evaluation to assess the compliance in using the new form and the accuracy of generated data.

In spite of the poor compliance of the use of the new form initially, the evaluation showed that by September 2002, 86% of the Institutions were compliant in using the new standardised form. Currently, MSL has now confirmed that all the institutions are now using the standard forms when ordering drugs. However, numerous errors were being made in the filling in of the forms. Consequently, ZIHP in collaboration with CBoH designed and developed guidelines to assist the institutions in completing the forms more accurately. The Guidelines were field-tested at a National Workshop in Lusaka, in June 2002, leading to further revision of the Requisition Form. These documents have now been disseminated to all institutions.

The Action Plans developed at the National Workshop, triggered a cascade of training in Logistics Management Systems and commodity ordering for all Districts and Hospitals in 5 Provinces. Except for Northern Province, ZIHP funded, and in collaboration with CBoH, provided technical support to these Workshops.

To extend the team at Central level, ZIHP in collaboration with CBoH, had been strategising, identifying and building capacity of potential resource persons, drawn from the all levels. These persons have been effectively used as facilitators, with the increase in the demand for training of health facilities. However, as a long term strategy, ZIHP in collaboration with DfID and CBoH have since early 2002, played an advocacy role and

finally succeeded in expediting the process of recruitment of Pharmacists at Central and Provincial levels.

With the subsequent recruitment of the Provincial/Hospital Pharmacists, an Orientation Workshop for the recruits was held with funding from DfID and technical support from ZIHP. This new team has been integrated with the old team of trainers, and have been spearheading the recent nationwide training of all Districts and Hospitals.

ZIHP assisted the CBoH to review and modify the Financial Administrative Management Systems Stores Management tools, which was also an input in the training package for the Financial Management manual for non-accountant staff.

ZIHP equally played a major advocacy role in fostering a mutual partnership between CBoH and Medical Stores Limited. This resulted in resumption of the monthly meetings, creating a forum for discussion of various logistical issues affecting not just the Centre, but more importantly, the periphery levels.

As another approach to further enhancing of logistics management skills, ZIHP in collaboration with CBoH designed and developed Job Aids for Hospitals, Districts and Health Centres. The aides have been printed and disseminated using the MSL facilities.

#### ***Norms and Standards for Key Interventions are Updated and Continuously Renewed (IR 5.4.1)***

ZIHP supported CBoH in the printing and dissemination of the second edition of the Integrated Technical Guidelines (ITGs) for frontline health workers. Almost all provinces and districts have collected their copies and distributed them to their health facilities. The dosage chart for the new first-line Malaria drug has also been incorporated into the second edition of the ITGs as an addendum. The pocket-size ITGs are still under development and are expected to be ready for printing before the end 2003.

During the year under review, ZIHP helped CBoH to lead a process for reviewing the Performance Assessment (PA) system and tools for the second time. The CBoH recognised that a radical change was needed in order for there to be any real improvements in the quality of services offered. The outcome of the meeting were recommendations for a new PA process which tries to incorporate the lessons learned from the numerous approaches that have been tried by different projects. The recommendations included changing Performance Assessment to a biannual rather than quarterly activity to allow more time for technical support and updating and finalising the draft Quality Improvement Guide intended to give help to managers and supervisors on how to conduct effective PA and technical support.

Regarding the Zambia Health Accreditation efforts started by the Quality Assurance Project which are now on hold, ZIHP supported one meeting to discuss the future of the accreditation program. At this meeting it was agreed that the CBoH would constitute a

small team to document experiences with hospital accreditation and the lessons learned in order to make recommendations for the future.

ZIHP has also continued to support biannual Quality Assurance meetings for provincial coaches. One meeting was held this year with logistical and financial support provided by ZIHP for the training of 31 QA coaches from the districts in Central province. The coaches will be expected to provide in-house technical assistance in QA within Central province. ZIHP is also encouraging the integration of QA into mainstream quality improvement of the public health system – the performance assessment.

***Improved consistency between the Performance Contracts, the Action Plan targets and the PA process***

ZIHP urged the CBoH this year to include in its work plan efforts to improve the consistency of the performance indicators used in the District and Hospital contracts, the annual Action Plans and Performance Assessments. During 2003, ZIHP assisted CBoH to review the three processes with the help of a local consultant. The recommendations are awaiting presentation to the CBoH Directors and, once their approval is given, work will proceed on amending formats in readiness for this year's signing of contracts.

***HMIS Further Developed to Provide Useful and Timely Data for Decision Making at All Levels (IR 5.4.3)***

ZIHP support to the Health Management Information System (HMIS) for this year has focused on improving the quality of data, and enhancing its use, especially at district level. Towards the end of July, focus was also extended to supporting the institutionalisation of the HMIS in all health-related Training Institutions.

**Improving Data Quality**

In response to numerous concerns from data users and stakeholders, during 2001/2, a Data Audit was conducted in 12 districts during the second quarter of 2002. A number of problems were identified ranging from technical issues to human resource shortages, all at district-level. These findings were initially disseminated to the provincial officers, some of whom requested technical support to resolve these problems. Meetings to discuss and address these problems were organised by Copperbelt and Central Provinces.

Except for Mporokoso, which did not send any officer to these meetings, 71 of the 72 districts in the country were covered by February 2003. Feedback from the participants indicates that the meetings were a success. ZIHP has since supported the printing of certificates of attendance which the CBoH has signed for the district staff.

**Production of Annual Statistical Bulletins**

As a continuation to the activities commenced earlier, the 2001 HMIS Bulletin was completed. Unlike the previous editions of 1999 and 2000, where the document was solely produced by central office of the CBoH, this version sought the involvement of the provincial office through a 3 day meeting supported by ZIHP. This strategy was extended

to the production of the 2002 bulletin, where, Data Management Specialists from selected provincial offices were invited to a bulletin drafting meeting for 5 days. The meeting which occurred in March 2003, was intended to build capacity in data analysis and interpretation. This meeting was a tremendous achievement because it was the first time ever recorded when all data from the districts would be submitted early. This success was a direct result of national wide consultations with the district staff on issues of data quality, timeliness of reporting and usage. By the end of March this year, the document was ready for circulation and ZIHP intends to work with the CBoH to set up a health editorial committee for next year.

#### **Preparations for the HMIS Review**

A number of meetings with the CBoH, DANIDA and CDC have so far been held to discuss the way forward with the review of the HMIS. It has been observed that the performance of the HMIS intrinsically calls for a re-evaluation of the system. Further, for every interested party to make any meaningful contributions, it is important that information on the current system is widely made available. This was the original concept behind the system, the implementation and post-implementation experiences. Activities towards producing an HMIS background document have been completed. The document was endorsed by the HMIS staff and was ready for publication by the end of the year in review. Beyond this support, ZIHP hopes to see the CBoH take the necessary leadership in the subsequent activities.

#### **Production of a Health Facility Booklet**

Since 1995, the Ministry of Health has had no official health facility list. ZIHP offered its support to produce an updated booklet. The booklet contains information about all health institutions categorized by: type, owner, number of beds and cots. This document should have been printed by February 2003, but the information coming from the districts during data management meetings suggested it was premature because some districts were not correctly represented. Most of the concerns have been considered and the document has since been printed and is ready for distribution.

#### **Review of 2<sup>nd</sup> Draft of the HMIS Reference Guide**

During the first quarter of 2002, ZIHP embarked on activities to produce a reference guide to be used in HMIS data management, especially for the district and facility levels. A number of reviews were done during the course of the year and by the end of December, a third draft was produced which should have been ready for the first print by September 2003. However, a change of strategy in June of this year, put this activity on hold. This change was as a result of the emergency and unplanned activity to prepare HMIS materials for Training Institutions which was more urgent than the Reference Guide.

#### **Support to Districts in Use of HMIS in Planning**

ZIHP has been supporting the CBoH, in meeting the Sector Programme Assistance milestones. Part of this responsibility, involved examining how much progress districts are making in setting realistic targets using the HMIS data for annual planning. It was noted that further data management support was required at district level. Kitwe,

Chibombo and Kabwe have been adopted for the 2003/04 planning period. This support involves running the actual process of cleaning data, basic trend analysis, and simple procedures for making targets. It is envisaged that this effort will be spread to other districts through exchange programmes.

#### **Integration of HMIS into Training Curricula of Training Institutions**

Over the past five years, attempts have been made towards introducing the HMIS in the training curricula for nurses, clinical officers and medical doctors. Although some nursing schools have been making efforts to include HMIS into the curriculum, the results have not been significant. This has been partly due to the lack of training materials for these institutions to use and the absence of tutors trained in HMIS. To take advantage of the current revisions to Training Institution curricula, ZIHP has supported the development of HMIS training materials. This process has involved reviewing the materials used during the introduction of the HMIS in 1997, and incorporating changes that have to create one package.

#### ***Nationwide Dissemination of Cost Sharing Guidelines (IR 5.5.1)***

##### **The Katete Video**

A video depicting the success of cost sharing activities in Katete was video produced in December 2002, as part of the efforts to increase advocacy. The video was disseminated to all 72 districts in the country and has been shown to various members of the community and the representative structures such as the Neighbourhood Health Committees, and District Health Boards. A total of 100 copies of the video were produced with 72 going to the district health offices, 9 of sent to the provincial health offices and 18 to a select number of cooperating partners within the country. Four runs of the programme were presented on television. The impact of a visual presentation has been overwhelming with some district vowing to emulate what Katete has been able to achieve while others like Kabwe have invited ZIHP to document aspects of payment-in-kind and community participation.

##### **Cost Sharing Under Attack**

The concept of Cost sharing continues to be attacked from various sectors of the society. Some of the attacks have come from the “Equity Gauge”, an organization that looks at the impact of the health reforms on households. In May, 2003 the organization funded a trip for members of parliament, who constitute the Parliamentary Committee on Health, Social Welfare and Community Development, to visit Chingola and Chama districts, the latter being one of the poorest districts in Zambia. Following that visit, there was a press statement made by these members of parliament calling for the abolition of cost sharing, citing that it hinders access to care for poor members of society. The newspaper article can be found in appendix 9.

To counter this negative publicity, an information package was presented to two members of the Parliamentary Committee on Health to share with the rest of the committee members comprising



- A video depicting the use of cost sharing funds and community participation in Katete district.
- A concise document prepared as a response to the call for scrapping user fees and providing additional information addressing the concerns expressed by the members of the parliamentarian committee
- The government exemption poster which outlines exemptions for the indigent members of society– in all about 20 posters were presented to each of the members
- Fifty copies of the Cost Sharing Policy Brief

The existence of the exemption poster came as a surprise to the two members of the committee, one of whom then suggested wider dissemination of the same in the constituencies and advised that some of this effort must be made in collaboration with the members of parliament.

In the past, more emphasis was placed on educating health workers, the District Health Management Teams and other co-operating partners in cost sharing guidelines. It is clear within the evolving context, that the key messages about this policy have not been disseminated broadly enough to reach all stakeholders, including members of parliament and those who have moved in to take up new government positions during the last few years. Further, the information on cost sharing has not trickled down to the general population for them to appreciate the benefits of the policy.

**"Cost Sharing is not just about resource mobilization or community financing of the health system, it is about community participation."**

*- Cost Sharing Poster*

#### **Dissemination to CBoH Board Members**

A special meeting for CBOH Board members is planned for end of October, 2003. This activity will be part of the effort to advocate and garner support for cost sharing at the highest levels of the political structures. It is also being done in response to the Board members felt need to provide advice to key stakeholders on how to ensure sustainable financial support for the health system. Cost sharing will undoubtedly be tabled as a viable tool for mobilizing local resources for the health system.

#### **The Development of Operational Guidelines**

Three operational guidelines have been developed with input from the Provincial Financial Specialists: Payment in Kind, How to Change User Fee Levels in the District and How to Access Cost Sharing Revenues from the District Health Office. The guidelines were developed in an effort to improve knowledge on the management of cost sharing at the district level and will be disseminated to the districts before year end with the district cost sharing manual and the additional posters.

### ***Development and dissemination of tools (IR 5.5.2)***

#### **Ownership of the District Cost Sharing Manual and Operational Guidelines**

The District Cost Sharing manuals developed during the second quarter were presented to the Provincial Financial Specialists. Ownership of the cost sharing policy among key policy makers and indeed the technical teams of the Provincial Health offices has been a challenge to the implementation process. By conducting a workshop to get input into the policy content of the manuals, ZIHP aimed to hand over ownership of these vital documents to the Provincial Financial Specialists. Input sought at a workshop specially convened for that purpose, was incorporated in the final drafts and will be used to training of district health office accountants.

The manual outlines the management tools for cost sharing and drew heavily on both the experiences gained in Katete and Livingstone and from Financial Specialists knowledge of the district accounting system. A third district, Kitwe, introduced the tools in October 2003.. The tools strengthen the financial management system and enhance transparency and accountability in the management of cost sharing revenues at the district level. The CBoH has since made a decision to introduce the tools in all 72 districts by January 2004. Although the tools and indeed the manual and guidelines were initiated and developed by ZIHP, CBoH has taken ownership as intended.

#### **Training in the Use of Cost Sharing Tools at District level - Kitwe**

Inputs from the districts were incorporated into the final draft of the cost sharing manual which was used in Kitwe in February 2003, to train 420 members of the district health system. The major benefits of using the tools relate to the district health system's increased capacity to account for all cost sharing revenue collected and the transparency with which the funds are managed and utilized. Following the training in, nine other districts in the Copperbelt province have expressed interest in the tools. ZIHP will provide funding, to the financial specialist based at the provincial health office for initial training that is required prior to the introduction of the tools at all health centres.

#### **Training in the Use of Cost Sharing Tools at District level – Eastern Province**

The dissemination manual was also used in Chipata during the first ever provincial dissemination workshop involving top management from 8 districts and 4 major hospitals in Eastern province in April, 2003. The managers expressed their commitment to the introduction of the cost sharing tools in their districts. Funding from ZIHP through the provincial financial specialist will be used to fund the initial training of personnel in charge of the health centres, since most of the district managers have all been trained. All subsequent training of the health centre staff and sensitization of communities about the cost sharing policy will be funded using the district government budget. This will bring to a total 19 districts out of 72 that are using the management tools designed by ZIHP with technical assistance from the Partnership for Health Reform.

The next phase of the training will cover all district accounting officers and health centre staff from the 72 districts. The Central Board of Health plans to introduce the management tools at all health centres throughout the country by January, 2004.

### **Radio Programmes**

Continued support was given to the Central Board of Health and its long distance learning programme for Neighbourhood Health Committee members. A script on the important role of cost sharing in the health reforms was used. Additional materials on the cost sharing experience were produced in November for the second run of the series of the radio programme for 2003 focusing on the importance of negotiation and the skills needed by Neighbourhood Health Committee members for this process in order to promote effective community participation. Additional content sheets covering the topic of Community Health Innovative Funds, was drafted and presented on radio.

### ***Models of Local Financing Analysed (IR 5.5.3)***

#### **The CHEWS Database and Training**

Following the implementation of the Community Health Education Welfare System Waiver (CHEWS) program in Kafue, the need for a database for collecting data on the distribution, use at health centre and redemption at DSWO of used waivers became apparent. A database has since been developed. In addition, twelve persons including the two DSWO officers in Kafue, DHMT accounting staff and Kafue district hospital information officers as well as officials from PWAS office in the MCDSS in Lusaka and Ministry of Finance were trained in September on how to use it.

To date the DSWO has paid out K2, 742, 000 (US\$548.40) in user fees for services provided to the beneficiaries of the waiver scheme. As a result of the prompt payments to the DHMT, holders of the waiver scheme are welcomed at health facilities and accorded the same respect as those paying user fees out of their own pockets. The success of this program cannot be overly emphasized. Not only does this it answer the very question of access to care by the poor - a contentious issue fuelling much of the discussion on the efficacy of cost sharing - but data collected during the monitoring of the program will be used to both educate and influence policy making on the issue of access to care for the vulnerable groups in society.

Kafue is a valuable example of how vulnerable groups might be taken care of in the face of cost sharing and financing reforms which require everyone to make a contribution towards the cost of the provision of health care services. So far, Kafue shows that the availability of funding or prompt reimbursements to the district health office for services provided to the vulnerable, is one of those critical conditions for the success of any program aimed at addressing the issue of the indigent.

#### **The Launch of the Kitwe Pre-Purchase Discount Card**

Kitwe DHMT launched its pre-purchase Discount Card on October 1, 2003 following a long and protracted discussion between the DHMT, the health centre staff and the community. Several pieces of work which included the costing of a possible payment scheme using utilization data for 2000 and 2001 and the training of 420 health staff in the use of cost sharing management tools was done prior to this. The entire launch and presentations done by the DHMT with the help of several drama groups were broadcast live on television Zambia.. CORPCO a business enterprise in the Kitwe immediately

purchased 300 discount cards for its employees on the same day of the launch. And the Deputy Mayor, invited to officiate the launch, expressed interest in obtaining cards for council employees.

### ***Improved Technical and Operational Coordination USAID in Zambia Programme (5.6)***

There has been improved coordination in sharing information amongst stakeholders involved in Reproductive and Child health. Scheduled quarterly stakeholder meetings exemplify this. These meetings discuss critical technical issues and provide a forum for sharing information on new initiatives, progress reports and defining reproductive and child health priority issues. The meetings provide opportunities to discuss co-funding and identify stakeholders comparative advantage in implementation of activities. ZIHP contributes strongly to these meetings through support to their preparation, documentation and follow up. Technical support is also critical during proceedings.

As the result of the provided TA in strengthening the co-ordination role of the CBoH, the first comprehensive orientation meeting of the PHO and DHMT representatives was conducted. This meeting provided the representatives with the information on new concepts and frame work on RH to be used in the 2004 planning cycle. During this meeting it was reported that provinces will be provided with funds by CBoH to develop strategic plans on implementation of IRH.

### ***Review data from DHS, HMIS, and Situation Analysis to determine their use in program impact reporting (5.7.2)***

ZIHP-wide monitoring and evaluation has been conducted through 3 main strategies: component specific monitoring of implementation activities, periodic ZIHP-wide reporting through the semi-annual and annual reports, and through conducting specific research, both ZIHP wide and component specific to review and evaluate interventions.

The 2003 ZIHP monitoring focus is on conducting an end of project household survey in the 12 demonstration districts and an additional case study in one of these demonstration districts. The survey will focus on household level information while the case study will provide in-depth information more on some mechanisms that have been used to provide support to health service delivery, and hence will tend to focus more on institutional support provided by the project.

The broad objective of the survey and case study is to evaluate the impact/effect of ZIHP wide interventions carried out during the 1999-2003 period. The studies will provide information on effectiveness of the approaches used to implement interventions in the four technical areas as well as gaps in programming that could be addressed in future.

### **Survey and case study preparations**

The end of project household survey preparations started with defining/reviewing the indicators to be measured. The indicators from the baseline survey were reviewed based on the technical areas of intervention i.e. Malaria, HIV/AIDS, Child health, Reproductive health. The review of indicators focused mainly on content and quality.

Preparations also included defining the scale of the survey (2000 households) and development of research instruments.

A contractor, DCDM Consulting Limited, was hired through a closed bidding process to carry out the end line survey in order to reduce time demands on ZIHP staff and assure quality work. An outsider will similarly be hired to conduct the case study, though with a much smaller budget. The research report from DCDM will be ready by January to facilitate write up of the technical report by ZIHP.

The case study preparations are under way with development of terms of reference. The actual study will be carried out between December and January 2004. The results of the two studies will be an integral part of the ZIHP end of project dissemination and documentation

### ***Sector Programme Assistance (IR 5.8.)***

During the fiscal year 2003, ZIHP assisted MOFED, MoH, CBoH, and USAID finalize and document the new disbursement mechanism to be used to disburse funds under this agreement to the Health Sector Basket. ZIHP, together with its partners, facilitated the opening of various bank accounts at both the Bank Of Zambia (BOZ) and Zambia National Commercial Bank (ZNCB) to be used as part of the disbursement mechanism which resulted in the Zambian Government (GRZ) receive from the US government \$1.6 million for GRZ financial year 2000 milestones.

During the year under review, ZIHP with other members of the SPA Steering Committee from MOFED, MoH/ CBoH and USAID, assisted in the documentation, review and agreement of the GRZ 2001 performance milestones. Specific disbursement amounts have been recommended for each Milestone within the guidelines of the Agreement and the current funding available for this trench totals U.S. \$ 2.0 million.

### ***C. Implications***

#### **With Regard to Policy**

Zambia is challenged by the HIV/AIDS epidemic and policy makers will have to address difficult questions. No single question is without a link with the HIV/AIDS epidemic. Development of capabilities to manage such issues will remain a big need.

#### **With Regard to Planning**

ZIHP should be prepared to support the full implementation of the revised performance assessment and supervisory system if it has to hold ground. The Financial Management training course is likely to create demand, therefore, more partners should be involved to support the implementation of the course.

#### **With Regard to Drugs and Logistics**

Great effort has been put in facilitating collaboration between different key services in CBoH and Medical Stores Limited. However, continued support is essential to deepen and improve the quality of this collaboration.

#### **With Regard to Quality and Performance Improvement**

If the revised performance assessment and supervisory system is well received by districts, ZIHP should be prepared to participate in the implementation of next steps.

#### **With Regard to the Health Management Information System**

Visits to districts and provinces indicate that capacity building is still needed at central and provincial levels. The most effective way of doing this is through a good combination of field support and appropriate documentation.

#### **With Regard to Cost Sharing**

Cost sharing continues to be highly sensitive. A lack of understanding of the key tenets of the policy abounds and for this reason, the health finance component must set aside much of its budget to drive and disseminate cost sharing to the larger community. Creation of ownership among key stakeholders and indeed the community will protect cost sharing from the current politically motivated attacks. Efforts must also be made to shift the method of implementation of this policy from that of a seeming vertical program to a national policy that affects all the districts in the country.

#### **With Regard to Monitoring and Evaluation**

There is a consciously coordinated process to facilitate the end of ZIHP. This presents an opportunity to document and disseminate lessons learnt.

### ***D. Challenges***

1. Creating ownership and understanding of the cost sharing policy amongst the key players and the community remains a huge challenge. There might be need to increase the cost sharing budget in order to inform and influence discussion of the cost sharing policy at the higher level and in the community.
2. In addition, finding sufficient financial resources to implement cost sharing management tools in all districts will be a big challenge, given that all budgets have been approved and allocated for the remainder of the project's life.

3. The Central Board of Health needs assistance and support to create funding criteria for the Training Institutions. Most training institutions are unable to meet their objectives with the current funding levels.
4. The use and quality of data in the Requisition Form at District level, and the use of the generated data by Districts and Central levels for informed decision making needs to be strengthened.
5. The compliance of use of the Quarterly Report form for Essential Logistics data being piloted in Southern province remains a challenge.
6. Great achievements and challenges have been encountered in implementing ZIHP. It is important to develop documentation that will help share these experiences and innovations applied to achieve the given levels of success and limitations faced.

### **Appendix 1: Topics Covered During the Better Health Campaign 2003**

The following topics were covered during the reporting period. Details report are available on each topic.

#### **October - Malaria in Pregnancy**

- Why is it such a problem
- The need to use treated bednets
- Intermittent Presumptive Treatment with Fansidar

#### **November – Humanitarian Crisis (Hunger)**

- Increase of disease in a food shortage situation
- Diarrhoea: safe water and good hygiene
- Diarrhoea: Early treatment is critical

#### **December – HIV/AIDS**

- Positive Living: What it is?
- Care and Support
- Physical wellbeing
- Stigma associated with HIV/AIDS
- Leaderships ( Government and other formal structures)
- Leadership (Community and Family)

#### **January - Child Health**

- Overview
- Good Feeding
- Well Child

#### **February – Leprosy & TB**

- Leprosy
- TB prevention and treatment
- TB treatment support

#### **March – HIV/AIDS- the ABCs**

- Abstinence

- Fidelity
- Condom use

#### **April – Malaria**

- New Drug Policy Stigma associated with HIV/AIDS
- Myths and Misconceptions about Fansidar
- Intermittent Presumptive Treatment with Fansidar for Pregnant Women

#### **May – ARVs**

- Overview
- Treatment options before ARVs
- Community support for treatment

#### **May/June – Specials**

- Child Health
- Measles
- SARS Special

#### **June/July – Rural Family Planning**

- Overview
- Family support and where to go for services
- Addressing myths and misconceptions

#### **July/August – PMTCT of HIV/AIDS**

- What it is
- Benefits of knowing your status
- Prevention- what happens after VCT
- Partner involvement at all stages

#### **August/September – Safe Motherhood**

#### **September – Distance Education for NHC Members**



## Appendix 2: HEART Campaign Status

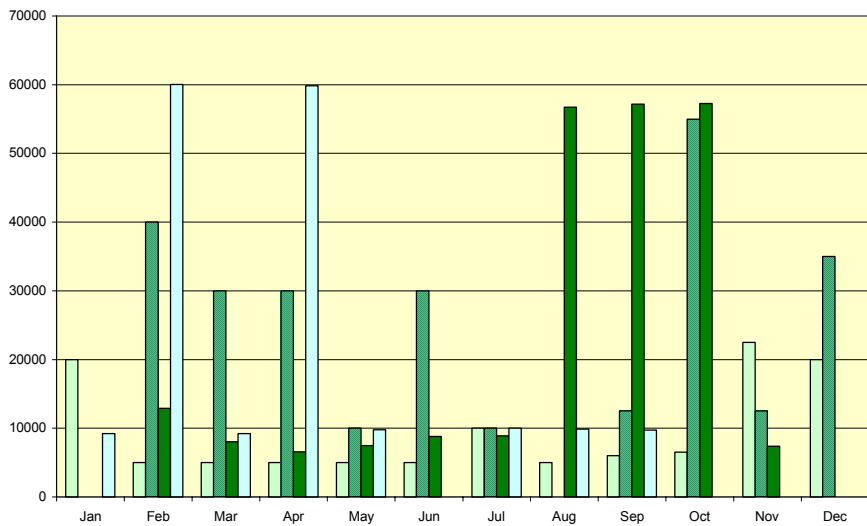


The 5 television spots for Phase III of the Heart campaign commenced on 30<sup>th</sup> December 2002 to 23<sup>rd</sup> March 2003. The spots were aired on both ZNBC and the African Broadcasting Network. These included two abstinence spots (“Virgin power, virgin pride”) and (Our boy), two spots with the message “you can’t tell by looking” (No Matter Boys and No Matter Girls), and two Maximum condom brand spot (Trust alone is not enough and the 4 C’s).

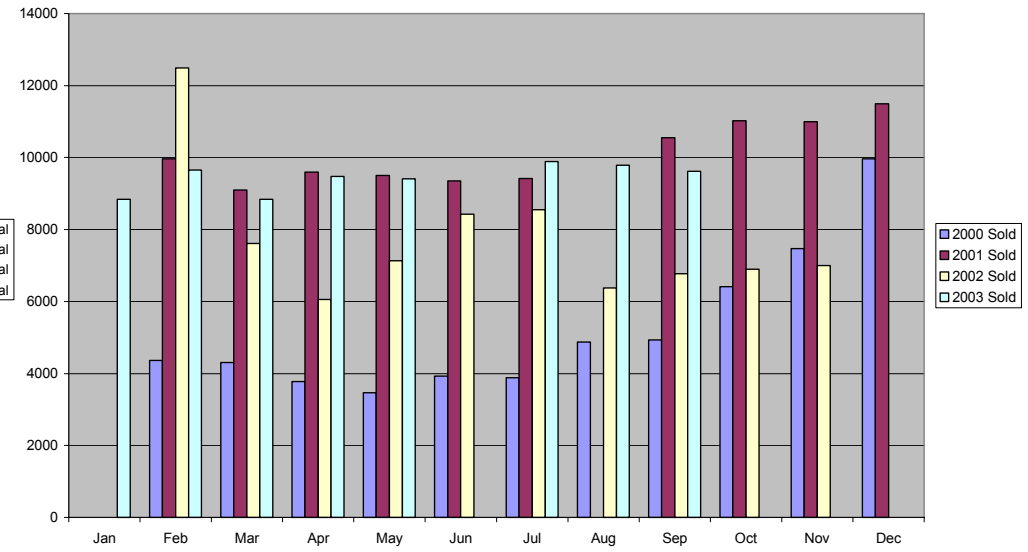
- 6 billboards were mounted which mirrored messages from 2 of the television spots in phase II (one on “you can’t tell by looking’ and another on abstinence ) and 2 messages from phase III (“not everyone is doing it-Virgin Power Virgin Pride” and “No matter how much you trust him”). The locations include; Kamwala market, Kafue road, Lumumba road, Livingstone, Ndola and Kitwe. 4 of the billboards were sponsored Coca-Cola.
- The Youth Advisory Group (YAG) comprised of 40 young people from different districts in the country met for 5 days in February 2003 for a comprehensive review of the campaign. This included exploring new audiences such as rural youth and as a result of the meeting, Phase IV of the HEART campaign will also focus on reaching rural youth through radio. The concepts for phase IV have been pre-tested in Chipata, Kasama, Livingstone and Lusaka with youth aged 13-19. The scripts were finalized by the YAG in a follow-up meeting in September. Production of the Phase IV spots has started.
- A complementary part of the campaign, “Youth in Crisis”, was also aired prior to the introduction of Phase III in an effort to reach stakeholders including the church, government, and parents to inform them of the situation youth face in relation to HIV. The leaders depicted in the spots include Ambassador Stephen Lewis- Special HIV/AIDS envoy to the UN secretary general, Dr. Brian Chituwo- Minister of Health, Bishop Joshua Banda and Bishop John Mambo.
- The second survey to evaluate the impact of the HEART Campaign has the filed work completed in the third and fourth weeks of August 2003. Enumerators have interviewed 1,200 youth in the 12 demonstration districts. The data is currently being analysed.

**Appendix 3: Trendsetters Data**

**Total Distribution by Month 2000-2003**



**Trendsetters Sales by Month 2000-2003**



**Appendix 4: Youth Activists Organisation Data**

To date YAO has run 31 Community Sexual Reproductive Health and Football Camps, reaching over 150,000 people. The following table contains details of the camps implemented in this reporting period:

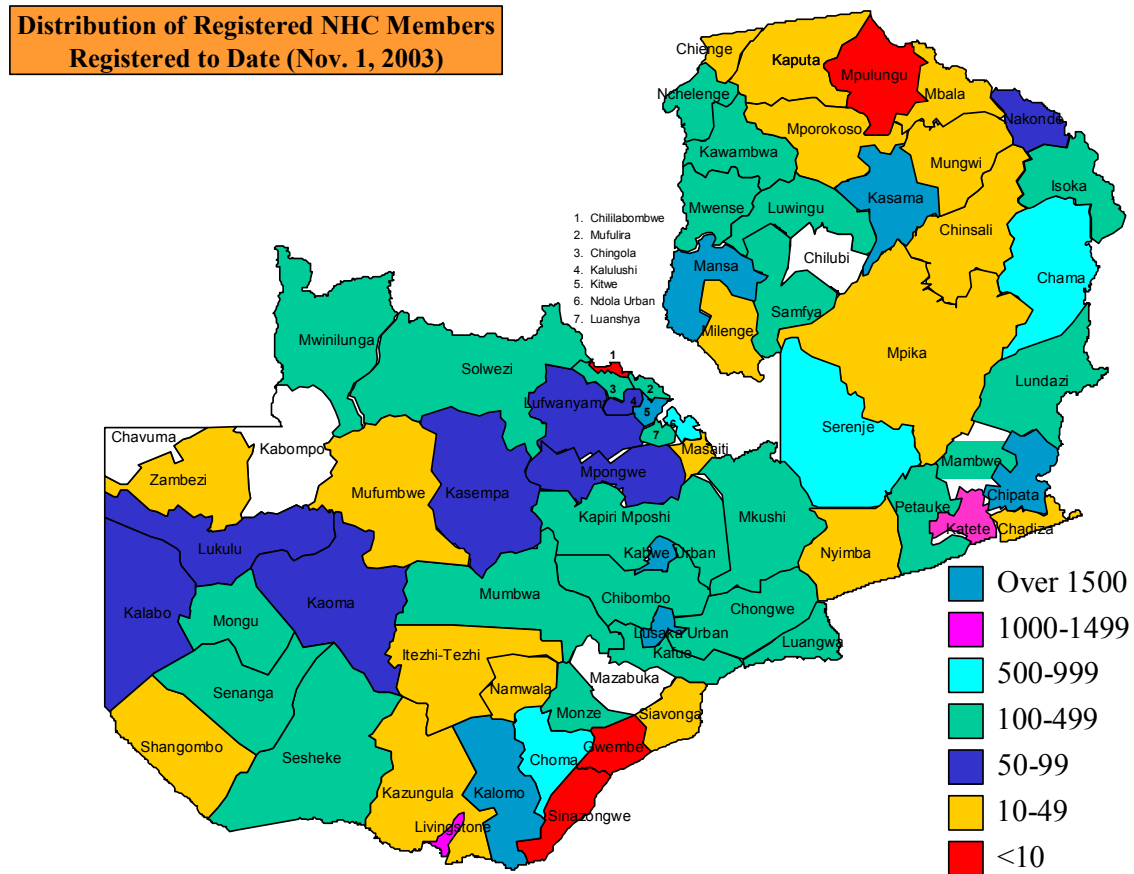
**Number of People Reached Through Community Football Camps**

<b>Audience &amp; Session Type</b>	<b>People Reached</b>	<b>People Reached</b>	<b>People Reached</b>	<b>People Reached</b>	<b>People Reached</b>	<b>People Reached</b>	<b>Totals</b>
<b>Location</b>	Senga Hill, Mbala, Northern	Luwingu, Northern Province	Kantu, Kabambwa, Luapula	Kabunda, Mansa, Luapula	<b>Nkanga, Lundazi, Eastern</b>	<b>Chizimba, Chama, Eastern</b>	
<b>Dates</b>	3-9 <sup>th</sup> May	27-3 April	25- 31 May	1 <sup>st</sup> -7 <sup>th</sup> June	27 July – 2 August	3-9 August	
Boys 14-20 yrs: SRH/HIV/AIDS info. & Soccer Skills	50	50	53	47	47	47	294
Girls 14-20 yrs: SRH/HIV/AIDS info. goal setting, decision making	38	127	510	73	267	4	1019
Coaches: SRH/HIV/AIDS information & Soccer Skills	5	5	8	5	6	6	35
NHC members: HIV/AIDS information and community action, Headmen, Traditional Healers	15	15	19	16	8	14	87
Parents: HIV/AIDS/FP information, communication and decision making	148	460	175	120	35	0	938
Community Members: HIV/AIDS MVU shows	6100	3136	1730	2040	0	0	13006
<b>Schools Outreach- boys</b>					287	261	548
<b>Totals</b>	6356	3793	2495	2301	650	326	15921

**Appendix 5: Africa Alive! Zambia Activity Summary**

<b>Activity</b>	<b>Materials distributed -# and type</b>	<b>Target audience- Estimated # of participants</b>
Stakeholders Meeting in Lusaka	<ul style="list-style-type: none"> <li>• Activities Report</li> <li>• Finance Report</li> </ul>	100 Stakeholders
Africa Alive! Zambia Strategic Planning Meeting in Ndola	<ul style="list-style-type: none"> <li>• Developed strategic plan, revised constitution, developed fundraising strategy, developed code of conduct</li> </ul>	12 National working group members
Final Road Show Concert in Lusaka	<ul style="list-style-type: none"> <li>• Consistent condom use</li> <li>• Abstinence</li> <li>• You can't tell by looking that someone is HIV/AIDS+</li> </ul>	Youth aged 15-24, in and out of school, 500 youths attended the concert
World Population Day concert in Solwezi	<ul style="list-style-type: none"> <li>• Protect and empower young girls before its too late</li> <li>• Delay marriage</li> <li>• Prevent unwanted pregnancies</li> <li>• Abstinence</li> <li>• Support for support PLWA</li> <li>• Parent Child Communication</li> </ul>	About 5000 people were in attendance
Peer Educators regional workshop	<ul style="list-style-type: none"> <li>• IEC materials, condoms</li> </ul>	70 peer educators from, Uganda, Malawi, South Africa Tanzania, Ethiopia, Kenya, Mauritius and Ghana
Weekly Radio Program on HIV/AIDS and Human Rights on Radio Phoenix	<ul style="list-style-type: none"> <li>• A rights based approach to HIV/AIDS, Focuses on stigma and discrimination</li> </ul>	Number not yet established

Appendix 6: Distribution of Registered NHC Members



### **Appendix 7: World AIDS Day Activities**

“Live and Let Live” was the slogan for the 2002 World AIDS Day Campaign intended to create a sustained focus on reducing HIV-related stigma and discrimination. Similar to 2001, ZIHP decided to extend its reach into the 12 districts in an effort reach more rural areas with commemoration activities. Staff travelled to Kasama, Mwense, Samfya, Kitwe, Ndola, Chama, Lundazi, Chipata, Kabwe, Chibombo, Kalomo, and Livingstone.

The objectives of District Support for World AIDS Day initiative were as follows:

1. To provide technical assistance to the DHMT in the planning and implementation of satellite activities and commemoration of World AIDS Day 2002.
2. To provide technical support to local NGO’s, drama groups, Peer Educators and clinic staff in coordination and implementation of activities.
3. To provide IEC materials to be distributed by Peer Educators, drama groups and clinic staff during World AIDS Day commemoration activities.
4. To distribute condoms and ensure local Peer Educators conduct condom demonstration.
5. To disseminate a report on World AIDS Day commemoration activities.

#### **Support to the Districts for World AIDS Day Activities**

ZIHP, with assistance from the Embassy of Sweden and UNICEF provided financial assistance in the reprinting of IEC materials including brochures and t-shirts for the 12 districts. UNICEF printed additional brochures for its own distribution for World AIDS Day in other parts of the country, particularly those areas suffering from food shortages. (See Appendix I for details on IEC materials)

In each of the above-mentioned districts, ZIHP technical staff worked with the District Health Management Team and World AIDS Day organizing teams. A number of activities were utilized in the commemoration of World AIDS Day and the following list highlights these activities:

- March and Candlelight Evening Service
- Sports
- Public awareness meetings, Workshops, Seminars for specific target groups such as young men or women, parents, church leaders or traditional leaders were utilized to promote HIV awareness.
- Debate & Essay Competitions
- Drama groups
- Peer Educators.

#### **Recommendations**

The following are recommendations for support for WAD activities next year:

1. Districts should be encouraged to plan activities earlier so that all stakeholders can be involved and organized in advance.
2. Fundraising should be done on a district level through the Task Force in place which includes the DHMT and NGOs. Private companies should be approached in advance of World AIDS Day itself to ensure that funds are available for activities without relying exclusively on the DHMT for support.
3. Encourage more PLHA to become advocates to eliminate stigma and discrimination while also answering questions related to HIV.
4. Given that some of the districts now have the capacity to carry out World AIDS Day activities without technical assistance from ZIHP, a consideration to expand to other districts, perhaps those where NHC strengthening is taking place, may be a better way to extend activities even farther.

### ***Conclusion***

In total, approximately **66,000** people were reached in 12 districts throughout activities leading up to and including World AIDS Day. This year provided many lessons for ZIHP in providing technical assistance to local DHMTs. The need for early planning was again emphasized as are the benefits for working in collaboration with other partners on the ground. It appears in many districts that more and more people are learning about World AIDS Day and perhaps learning to speak more openly about HIV and share information with friends and other community members.

There is also a need to include people living with HIV/AIDS as advocates and educators within their own communities. While IEC materials remain necessary in all districts, where technical assistance is no longer required, ZIHP may extend its future activities into other districts.

**Special thanks is given again to SIDA and UNICEF for their generous contributions towards the printing of IEC materials. Through this collaboration with ZIHP, over 95,000 brochures were distributed with an additional 34,000 posters in addition to the other materials shared with the districts.**

## ***Appendix 8: Youth Netball And Sexual Reproductive Health Netball Camps For Girls***

### **I. Jerusalem Camp**

The camp was held from the 24<sup>th</sup> – 30 August, 2003 in Jerusalem village of Chipata district. Fifty girls were in camp with 5 netball coaches were trained during the school's out reach sessions. Other people that attended community health sessions included 16 NHCs, 21 TBAs, 19 mothers, 38 fathers and 12 headmen. About 1800 people came for the MVU shows

### **II. Rukuzye Camp**

The Rukuzye camp ran from 31<sup>st</sup> August - 6<sup>th</sup> of September in Chipata district. As with the Jerusalem village, 50 girls were in camp with 4 coaches trained.. Other audiences reached were 78 boys, 58 women's groups, 18 fathers, 65 mothers, 11 head men and 14 traditional healers. Also about 1935 people were reached during the mobile video unit shows

The program went well, focusing on addressing issues that affect girls around the different communities. A lot of issues were raised with regard to SRH, with special emphasis on gender and women's vulnerability. Besides the usual activities, YAO integrated to the camp with the Theatre for Community Action which was very good.

### **Findings**

At first the girls seemed too shy to express their views but as time went on, they opened up. Girls are also quite difficult to control in terms of observing order and noise, as they seem to be more outspoken than the boys. Knowledge levels were average especially on sexuality. Other issues that came out from the sessions were the aspect of girls encouraging sex in exchange for money or gifts.

The outreach sessions however with the boys were more participatory and the knowledge levels seemed to be very good, compared to girls indicating that talking to girls was more useful to encourage gender equity.

### **Constraints**

- It is difficult for girls in the community to talk about sex in presence of men
- Some girls had babies which disturbed the sessions a lot because they had to go in and out breastfeeding and attending to them

### **Achievements**

- The turn out was good for the outreach sessions
- The MVU's were good overseeing a good number of people
- The integration of Theatre for Community Action was also very
- The games for the sessions were interesting



**Appendix 9: EBA Activities in Districts**

*EBA programme*

<b>District</b>	<b>No. Of workplaces</b>	<b>No of workplaces with trained agents</b>	<b>No of EBAs in the district</b>	<b>No of active agents</b>	<b>No of employees reached</b>	<b>Pop. Reached at 5.9 children per family (DHS 2002)</b>
Chibombo	21	12	30	30	11,000	64,900
Kabwe	38	19	24	11	15,851	93,521
Ndola	105	40	57	52	25852	152,527
Kitwe	50*	28	31	27	30,723	181,266
Kasama	32	38	40	32	12821	75,644
Chipata	18	15	21	14	5,318	31,376
Lundazi	26	24	26	24	12049	71,089
Chama	No program					
Kalomo	43	32	33	33	5,726	33,783
Livingstone	44	23	39	31	18400	108,560
Samfya	No program					
Mwense	No program					
<b>Total</b>	<b>377</b>	<b>233 (62%)</b>	<b>301</b>	<b>254</b>	<b>137,740</b>	<b>812,666</b>

## ***Appendix 10: NHC Strengthening Package***

In 1991 the Zambian Ministry of Health, as part of its Health Reform program, began to promote community involvement to bring essential health care as close to the family as possible. Fifty percent of Zambians are not within normal walking distance of a clinic. So Neighbourhood Health Committees were created to be a link between the clinics and the communities. The approximately 300,000 NHCs, countrywide, needed to be strengthened to be effective health promoters and community mobilizers. ZIHP's major obligation within its six- year duration is to assist CBoH to attain its health reform vision of providing "equitable access to high quality, cost effective interventions, as close to the family as possible." Building community partnerships was a basic component of the reforms. Partnership networks were being encouraged to enable communities to shift from a legacy of dependence that characterized the health system through three decades of the second republic rule, by assuming a more active role in promoting and owning health. The Neighbourhood Health Committee (NHC), made up of community volunteers, was designated as the root unit in the health structure, providing the link between a health centre and the community.

The focus this year has been on the scaling up, beyond the demonstration districts, of the NHC strengthening package, also provide refresher TOT and roll out to the demonstration districts and the development and installation of a data base.

The package has several elements:

- Training of trainers in Participatory learning in action and the essential health care package
- A roll out of the training to all the health centres in selected districts
- Materials to support the training:
  - The Guide to the Essential Health Care Package
  - The PLA Guide
  - A Leadership Manual
  - A Guide to Resource Mobilisation and Proposal Writing
  - Small Grants Guide
  - NHC Information Cards for Action
- Distance Education, Operations Research and Case Studies

### ***Achievements***

1. All the twelve demonstration districts received TOT refresher and some districts have roll out.
2. the non ZIHP districts that indicated in their action plan that they would be rolling out the training received technical and/or material support from ZIHP. It has also been observed that a number of non ZIPH districts conducted TOT and rolled out without informing ZIHP, such as Luanshya and Sesheke.
3. A data base to capture community activities and initiatives has been developed and has been installed so far in three districts of the twelve demonstration districts.
5. As a result of the NHC strengthening training, a number of NHCs have mobilized resources locally and also accessed from various funding institutions. For example, up to US\$ 270,000 has been accessed from ZAMSIF. Other communities have been able to be funded from CBoH's Community innovation Fund (CHIF)
4. Several districts have used basket fund to purchase radio cassette players and sets of audio cassettes with the Our Neighbourhood programme.