Zambia

Final Country Report

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Acronyms

ACNM	American College of Nurse-Midwives
AIDS	Acquired Immune Deficiency Syndrome
ARO	Africa Regional Office (SEATS)
CA	Collaborating Agency
CBD	Community-based distribution
CE	Continuing education
CPR	Contraceptive prevalence rate
CQI	Continuous quality improvement
CYP	Couple-years of protection
DANIDA	Danish International Development Agency
DFID	Department for International Development (formerly ODA)
DHMT	District Health Management Team
EU	European Union
FGD	Focus group discussion
FP	Family planning
FPLM	Family Planning Logistics Management Project
FPS	Family Planning Services Project
GNC	General Nursing Council
GRZ	Government of the Republic of Zambia
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (German Technical Association)
HIV	Human immunodeficiency virus
IEC	Information, education and communication
IPCC	Interpersonal communication and counseling
IR	Intermediate result
IUD	Intrauterine device
JHU/PCS	Johns Hopkins University/Population Communication Services
JICA	Japanese International Cooperation Agency
JSI	John Snow, Inc.
LDHMT	Lusaka District Health Management Team
MAPS	Midwifery Association Partnerships for Sustainability
MCH	Maternal and child health
MIS	Management information systems
MMD	Movement for Multiparty Democracy
MOH	Ministry of Health
MWRA	Married women of reproductive age
NCDP	National Commission for Development Planning
NGO	Non-governmental organization
NHC	Neighborhood Health Committee
ODA	Overseas Development Administration
OTJ	On-the-job
PHC	Primary health care

PHP	Primary Health Provider
PHN	Population, health and nutrition
PIR	Program Improvement Review
PLA	Participatory Learning and Action Exercise
PPAZ	Planned Parenthood Association of Zambia
PR	Performance result
PSI	Population Services International
PVO	Private voluntary organization
PY	Project year
QOC	Quality of care
RH	Reproductive health
RHC	Reproductive health care
RHII	Reproductive Health Integration Initiative
SEATS	Family Planning Service Expansion and Technical Support Project
SO	Strategic objective
STI	Sexually transmitted infection
TFR	Total fertility rate
TFU	Trainee follow-up
TOT	Training of trainers
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UTH	University Teaching Hospital
VSC	Voluntary surgical contraception
WLI	Women's Literacy Initiative
WRA	Women of reproductive age
WV	World Vision
YFHS	Youth-Friendly Health Services
ZFPS	Zambia Family Planning Service
ZIHP	Zambia Integrated Health Package
ZNA	Zambia Nurses Association

I. EXECUTIVE SUMMARY

The Family Planning Service Expansion and Technical Support (SEATS) Project's involvement in Zambia began during SEATS I (1989-1995) when the Africa Regional Office (ARO) completed a comprehensive assessment of the population and family planning (FP) sector in Zambia and provided some preliminary technical assistance to the Planned Parenthood Association of Zambia (PPAZ). In 1994, Zambian officials participated in a regional dissemination meeting for the Sub-Saharan Africa Urban Family Planning Study, which stimulated their interest in expanding urban FP initiatives in Zambia.

Under SEATS II, Zambia has been one of very few countries involved in nearly every component or type of activity SEATS supports, including subprojects, special studies, Special Initiatives and regional activities. As Zambia is the most urbanized country south of the Sahara, local officials and SEATS staff developed a strategy which focused on urban family planning expansion and improvement, with particular emphasis on the needs of youth, who comprise a large and, to date, inadequately served portion of the population. The SEATS strategy in Zambia was to:

> **Assist the United States Agency for International Development (USAID) in achieving its strategic objective – increased use of integrated child and reproductive health and HIV/ AIDS interventions – through an urban-based approach to enhanced and expanded service delivery, integrating SEATS Special Initiatives and resources wherever possible.**

The SEATS strategy was implemented over the past four years within a context of rigorous health sector reform being undertaken by the Government of Zambia (GRZ). Elements of the reform movement, including training bans and staff delinkage (the severing of personnel from the government-funded civil service rolls), presented enormous challenges to the successful completion of subprojects and achievement of program goals and objectives. The broad range of SEATS activities available to the Zambian health system, however, allowed for shifting emphasis during times of difficulties related to reform, and consistent effort applied to supporting the National Health Policy and USAID's strategic objective.

The SEATS Zambia country program included the following major components:

- Subproject: Expansion of Family Planning Services in Lusaka Urban District;
- Subproject: Lusaka Urban Youth;
- Subproject: Zambia Nurses Association (ZNA)/Midwifery Association Partnerships for Sustainability (MAPS);
- Reproductive Health Integration Initiative (RHII)/Performance Result 2 Site: World Vision/Zamtan;

- Participation in regional activities.

Of particular importance in implementation of the Zambia program was the extensive collaboration fostered among multiple donors and collaborating agencies (CAs). Each SEATS-supported activity was carefully designed to maximize the resources already or concurrently invested by other groups. SEATS collaboration with such entities as the USAID/Zambia-funded Zambia Family Planning Services (ZFPS) Project, CARE, the FOCUS Project and others lent greater efficiency and increased sustainability potential to each of the subprojects and Special Initiatives.

With the close of the SEATS program in Zambia, significant achievements are becoming clear through the composite information generated by final studies, evaluations and exercises such as the mini-participatory learning and action exercise (PLA). SEATS has made important contributions toward:

- **improving access to services** – SEATS-supported clinics are youth-friendly and Youth Corners are operating in two pilot clinics; nurses, midwives and other providers countrywide have been trained in the delivery of youth-friendly services; 20 youth peer educators have been trained;
- **improving quality of services** – communities have become involved in identifying needed improvements; supervision tools have been developed and are being utilized; waiting time for services has been reduced;
- **improving human resources development and technical competence** – service providers have received new and updated technical training; trainee follow-up tools reveal as much as 70 percent learning retention six months after training; and
- **strengthening institutional capacities** – health centers have formed quality teams for ongoing problem identification and resolution; ZNA has increased its member services and management; sustainability plans were developed and initiated under each SEATS activity.

These are each important aspects of the Government of Zambia's vision: "to provide equitable access to cost-effective, quality healthcare as close to the family as possible." SEATS has supported this vision, and the principles and specific objectives and targets which further
define it.

Much work remains to achieve the sector goals and make the GRZ vision a reality for all Zambians. The context of health reform continues to present challenges to effective implementation of programs, particularly those that emphasize human resources development – a necessary component to strengthening any service or institution. Local and external resources are stretched thin, and the sustainability of activities implemented under donor support is not assured. The gains of today's development programs can be easily diluted, even reversed, by shifting priorities and urgent needs of tomorrow.

SEATS strongly urges GRZ, USAID and others to build on the activities that are so promising – youth-friendly health services (YFHS), public-private partnerships, ZNA capacity building, data-driven decision-making and more; and to continue to invest in those efforts which promise results and achievement of the highest order goals and objectives.

II. PROJECT BACKGROUND

A. Country Background

Zambia is a landlocked southern African nation with a population of 9.1 million, sharing borders with eight other countries. The country is divided into 9 provinces and 61 districts. It is the most urbanized African country south of the Sahara, with nearly half its population residing in urban areas.

Zambia gained independence from Britain in 1964. It was the first British territory to become a republic immediately upon attaining independence. While education and health services were greatly expanded in the post-colonial period, population services were not a development priority in independent Zambia. In the 1980s, the adverse effects of rural to urban migration awakened the interest of policy makers. The National Commission for Development Planning (NCDP) drafted a National Population Policy that was launched in 1989. Among its objectives are to:

- Initiate, improve and sustain measures aimed at slowing the nation's high population growth rate;
- Enhance the health and welfare of the population and prevent premature death, particularly among high-risk groups of mothers and children;
- Ensure that all people have the right to decide the number and spacing of their children, and have the information, education and means to do so.

The main targets of the Population Policy are to:

- Reduce the population growth rate from 3.7 percent in 1989 to 3.4 percent by the year 2000 and to 2.5 percent by the year 2015;
- Reduce the total fertility rate (TFR) from 7.2 to 6.0 by the year 2000 and to 4.0 by 2015;
- Make family planning services available, accessible and affordable to at least 30 percent of adults in need of services by the year 2000.

B. Demographic and Health Indicators

According to the 1992 census, youth age 10-24 comprised 37 percent of Zambia's population, a group especially vulnerable to unwanted pregnancy and STIs/AIDS. Eighty percent of women admitted to hospitals for abortion complications were less than 19 years old. HIV prevalence was high, and growing. In 1997, 17 percent of

pregnant women were HIV positive. The 1992 Demographic and Health Survey found a TFR of 6.5. Women of reproductive age (WRA) comprise 23 percent of the population. Women begin childbearing early, with a median age at first birth of 18.5 years. Among girls aged 15-19 years, 34 percent have begun childbearing. The contraceptive prevalence rate (CPR) for modern methods is 7 percent for all WRA, and 8.9 percent for married women of reproductive age (MWRA). Urban prevalence is 15.3, compared with 3.2 for rural MWRA. The maternal mortality rate is estimated at 940 per 100,000 live births, and the infant mortality rate is 112 (*IPPF Country Profile: ZAMBIA*, 1999).

C. The Zambian Health Care System

When Zambia attained independence, medical care was made free for all residents. As Zambia's economy declined in the 1970s and 1980s due to falling copper prices and poor industrial and agricultural output and policies, the health sector was adversely affected, as evidenced by a deterioration of infrastructure; flight of professional staff; shortages of drugs, supplies and equipment; worsening service conditions for government workers; and an increase in epidemics, infectious diseases and malnutrition.

These conditions persisted into the 1990s. The Movement for Multiparty Democracy (MMD) Government was elected in October 1991, ending 27 years of one-party government. A National Health Policy, published in 1992, outlined the new structure of the Ministry of Health and a comprehensive design for health services reform under the new government. Priority areas include:

- Decentralization of management to the district level;
- Formation of autonomous district health boards;
- Introduction of cost sharing;
- Improved availability of drugs and medical supplies; and
- Enhanced human resources development.

The Ministry of Health has moved aggressively to implement the decentralization and restructuring of the health care system. In 1993, a medical fee system was introduced for curative care and admissions. Care for children under five, antenatal and family planning services remained free of charge. Zambian health policy endorses fully integrated service delivery, although it is not universally practiced. Family planning services are provided as part of Maternal and Child Health (MCH) services. The development of "family health corners" in every health center has been promoted as a measure to provide integrated services.

National Family Planning Guidelines have been developed, reflecting the core themes of the health reform movement in emphasizing decentralized management and implementation, integration of services, quality of care and district capacity

building. Family planning has been re-conceptualized as a major part of reproductive health.

While Zambia's national family planning program is founded on the premise that access and information are basic rights of individuals and couples, until recently, family planning has not been accorded priority in health plans or in the training of professional staff. Some of the key constraints of the program have included lack of trained staff; very limited availability and use of long-term and permanent methods; poor access to services; and a poorly developed contraceptive logistics system to support service delivery. Difficult social conditions have posed an enormous challenge to the provision of services. Extreme poverty sometimes forces very young people into having sex at a very early age in exchange for gifts or money, exposing them to risks of unwanted pregnancy and STIs/AIDS. It is only recently that the special needs of youth have been identified and addressed in the planning and delivery of services.

D. The Lusaka Urban District

During the 1980s, expanded access to rural health services became a priority, leading to an increase in the number of rural facilities and services. Urban services did not keep pace with population growth during the same period.

Lusaka Urban District, comprising Zambia's capital city and vast peri-urban areas on its periphery, has doubled in population over the last decade to an estimated 1.2 million. Its growth rate is 6.7 percent per annum (national average 3.4 percent) due to in-migration from rural areas and high fertility. Women of reproductive age are estimated to number some 273,000 in Lusaka. About 75 percent of the population live in high-density compounds surrounding the city, where infrastructure is extremely poor. Access to clean water, sanitation and health facilities is inadequate; roads and transport are insufficient and poorly maintained. These conditions and widespread poverty pose an enormous challenge to the already strained health system.

Primary health care (PHC) services in Lusaka are provided by 22 urban health centers, 9 of which are large referral centers with maternities, and 13 of which provide more limited services focusing on MCH and some outpatient care. The average catchment population for Lusaka health facilities is around 50,000. Health centers are managed by the Lusaka City Council acting as the Lusaka Urban District Health Management Team (LDHMT). The city is divided into eight zones, with each zone supervised by a Zonal Public Health Nurse.

The University Teaching Hospital (UTH) is a 1,245 bed hospital, providing secondary and tertiary care for Lusaka residents and serving as a national referral center. UTH is also a major provider of PHC, as many patients lack confidence in health centers and attend UTH with minor problems which could be handled at the health center level. With shortages of staff, equipment and space, UTH finds it difficult to handle referrals.

Health services in Lusaka are also available at approximately 200 private clinics, a few industrial and non-governmental (NGO) clinics, and through more than 200 traditional healers.

Several donors are supporting improvements in general health service provision in Lusaka Urban District. The World Bank is assisting in the development of an urban master plan for the city. Irish AID has built maternity wings at seven of the urban health centers and Germany (GTZ) at another; and the British Department for International Development (DFID, formerly Overseas Development Administration - ODA) is providing general medical inpatient facilities in the same eight centers. United Nations Children's Fund (UNICEF) supports MCH activities through training and provision of kits, while Denmark (DANIDA), Japan (JICA) and the European Union (EU) have all provided equipment. Planned Parenthood Association of Zambia (PPAZ) has, until recently, been the major provider of family planning in Lusaka.

E. Family Planning Services in Lusaka District

In the area of family planning, CARE, as part of a larger development program, initiated a project in 1994 providing training, equipment, supplies and technical support to eight health centers in the Lusaka District. The urban clinics which were not included under the CARE project showed a clear need for support in order to improve delivery of family planning services and keep pace with the rapid expansion occurring in assisted clinics.

Although FP services are, in principle, to be delivered as an integral part of MCH services at all government health facilities, in practice the services are limited, not seen as high priority and strongly influenced by health care provider bias. Several clinics (including UTH) restrict delivery of FP services to one or two specific times per week, or halt them during other emergencies (i.e., cholera outbreaks). In others, FP clients are required to wait while antenatal and immunization clients are attended first. Prior to the CARE project, training in family planning for most service providers was limited to the minimal, theoretical input provided during basic medical, nursing or midwifery courses. A small number of midwives were also trained as Family Health Nurses, which included training in FP. However, this course was stopped pending resolution of issues about responsibility for training under the health sector reform program. No refresher training was provided to the majority of staff in recent years. Understanding of family planning methods and of policy governing their provision remained outdated.

Lack of training also restricted clients' choice of contraceptive methods. Depo Provera was only being offered through a trial in CARE-supported clinics. Similarly, outside of the CARE-supported clinics and UTH, only one government clinic offered intrauterine devices (IUD); all others provided only pills and condoms. These latter methods have been affected by frequent stock-outs at the clinics, further reducing client confidence in family planning services.

Clinics in Lusaka have also suffered from a lack of adequate space and equipment for the delivery of FP services. While newer clinics are spacious, older clinics, particularly those built by and with the community, have inadequate space. Poor organization of services within some clinics resulted in severe overcrowding in some areas and underutilization of others. FP was not seen as a priority and, therefore, usually competed unsuccessfully for space with antenatal, immunization and growth monitoring services. Equipment for internal examinations and for taking blood pressure was limited, if available at all. There has also been a severe lack of medical equipment for sterilization.

Family planning services offered through UTH generally suffer from the same constraints found at the clinics, although a wider range of methods – including NORPLANT® and voluntary surgical contraception (VSC) – are offered. Few clinical staff at UTH have had any recent training in family planning; equipment is

lacking; and the organization of services for outpatient family planning clients, for maternity cases and for post-abortion patients, could be significantly improved.

It is within this overall context that SEATS II began working in Zambia in 1995.

III. GOALS AND OBJECTIVES

A. Zambia Health Sector Reform

The vision of Zambia's health sector reform is "to provide equitable access to cost-effective, quality healthcare as close to the family as possible." The principles of health reform are sustainability; leadership at all levels, including the community; accountability for action, results and finances; and partnerships at all levels based on the different responsibilities of stakeholders.

The strategies and actions set forth in the Zambian Health Reform are designed to link the vision and principles of the health reform to the structures that are in place and their functions and, most important, to sustainable health improvements for the people of Zambia. Strategies as articulated by the GRZ include:

- **Accelerated implementation to achieve results**. Specific actions and innovations have been defined to develop and implement integrated service delivery systems.
- **Improved structures and functions**. Restructuring to improve the efficiency and effectiveness of government mechanisms includes major revisions in human resources training, deployment and management.
- **Advocacy for health reform**. The Ministry of Health (MOH) will monitor perceptions and transmit accurate information to all Zambians about the health reform.

Within the context of health reform, there is a reorientation from highly centralized vertical programs to decentralized integrated programs. Major components of the GRZ's health reform are:

- Decentralization
- Financial and performance accountability
- Redirection of funding to the primary care levels of service delivery
- Definition of essential packages of services and interventions
- Cost-sharing and referral
- Improved technical competence
- Community involvement and ownership
- Private sector participation
- Promotion of integrated health services
- Delinkage of personnel from civil service
- Donor coordination

The health reform movement has been evolving with mixed success. Many health staff are confused by frequent changes in implementing reforms. For example, delinkage had many staff concerned for their positions and scrambling to apply for more certain employment. Delinkage was then put on hold, but the panic and uncertainty caused considerable harm to staff motivation. A training ban was instituted while the shifting of personnel was taking place, and the training ban lasted even after delinkage was put on hold. This further depleted staff morale and caused ongoing projects and programs to revise their objectives and activities mid-course. There do not appear to be formal systems to monitor the effects and impact of the health reform, though many believe that overall the impact is not positive.

B. USAID/Zambia Results Package

USAID/Zambia has developed the Zambia Integrated Health Package (ZIHP) to support the vision and implementation of health reform which began following the democratic transition in 1991. Prior to ZIHP, the Zambia Family Planning Services (ZFPS) Project was USAID's principal mechanism to support reproductive health objectives in Zambia. The guiding principles of USAID's efforts focus on integrating USAID support into the Zambian health reform, supporting the integrated delivery of population, health and nutrition (PHN) interventions, partnerships (i.e., between NGOs and districts, NGO networks, the network of institutions responsible for training providers, communities and health structures), and Zambian ownership of program activities.

The strategic objective (SO), "**increased use of integrated child, reproductive health and HIV/AIDS interventions**, in partnership with the GRZ, other donors and partners," will lead to the goal of **sustainable improvements in the health status of Zambians.** The prioritized interventions of ZIHP include:

- An integrated adolescent package;
- An integrated promotive/preventive package for women caring for children;
- An antenatal care package;
- A safe pregnancy package;
- An integrated promotive/preventive package for men; and
- Integrated curative care packages.

Five intermediate results (IR) are expected to contribute to the SO: each IR focuses on the delivery of target group-specific integrated intervention packages. The IRs are:

1. Increased demand for PHN interventions among target groups;
2. Increased delivery of PHN interventions at the community level;

3. Increased delivery of PHN interventions by the private sector;
4. Improved health worker performance in the delivery of PHN interventions;
5. Improved national policies, planning and support systems for PHN interventions.

IV. SEATS COUNTRY PROGRAM AND STRATEGY

A. Country Strategy

SEATS offers a multidisciplinary approach to family planning services which, while focusing on service delivery, has in-house strengths in such areas as management, quality of care, reproductive health, information, education and communication (IEC), training, management information systems (MIS), policy development, finance and sustainability. The SEATS strategy in Zambia was to:

> **Assist USAID in achieving its strategic objective – increased use of integrated child and reproductive health and HIV/AIDS interventions – through an urban-based approach to enhanced and expanded service delivery, integrating SEATS' Special Initiatives and resources wherever possible.**

This strategy was implemented through subprojects, Special Initiatives and studies focused on family planning service delivery, and inclusion of Zambia in regional activities. The implementation strategy was designed to enhance and broaden the range of providers, target groups and types of services provided. SEATS II activities were designed to complement and enhance existing programs and contributions of cooperating agencies and donors. These include, but were not limited to:

- USAID Zambia Family Planning Services (ZFPS) Project – a five-year (starting in 1995) bilateral project contracted to John Snow, Inc. (JSI) and implemented with a variety of institutions. ZFPS focuses on increasing modern contraceptive use and expanding access to a variety of services that support USAID's PHN sector SO.
- CARE Community Family Planning Project – targeting populations in the urban and peri-urban areas of Lusaka with strengthened FP service delivery;
- Johns Hopkins University/Population Communication Services (JHU/PCS) – the IEC component of ZFPS, assisting young men and women to gain access to reproductive health information and services;
- Operations Research/Population Council – a component of ZFPS addressing questions related to strengthening reproductive health (RH) service delivery;

- Contraceptive Social Marketing/Population Services International (PSI) – creating demand for and making available contraceptive products on a re-supply basis to low-income populations. This includes the marketing of *Maximum* condoms nationwide through retail, health, workplace and community-based outlets.

B. Country Program

SEATS II began in January, 1995. In addition to a core strategy to expand access to quality, sustainable family planning and reproductive health services among underserved populations, several Special Initiatives (SI) were designed to enhance and broaden the range of providers, target groups and types of services provided. These include:

- Urban II Initiative: Maximizing Urban Resources;
- Reproductive Health Integration Initiative (RHII);
- Midwifery Association Partnerships for Sustainability (MAPS);
- Youth Initiative
- Women's Literacy Initiative (WLI).

Zambia is one of very few countries in which the full range of SEATS II activities – subprojects, studies and Special Initiatives – was implemented. With the exception of the Women's Literacy Initiative, all of the SEATS' Special Initiatives were integrated in the Zambia country program and subprojects; and all contributed important support to the Zambia health reform vision and to USAID's strategic framework. The activities and subprojects frequently collaborated to maximize training opportunities and technical assistance, as well as to ensure that they collectively moved in the direction of improving access to services for youth and other underserved segments of the population.

The composition of the country program supported by SEATS over the last four years has included:

- Subproject: Expansion of Family Planning Services in Lusaka Urban District;
- Subproject: Lusaka Urban Youth;
- Subproject: Zambia Nurses Association (ZNA)/Midwifery Association Partnerships for Sustainability (MAPS);
- Reproductive Health Integration Initiative (RHII)/SEATS Performance Result 2 Site: World Vision/Zamtan;
- Participation in SEATS regional activities.

The implementation and results of these activities are described in the following sections.

V. IMPLEMENTATION OF SEATS II IN ZAMBIA

The subprojects and Special Initiatives that SEATS supported in Zambia were designed to be complementary and to support the GRZ national health policy and USAID/ Zambia's strategic objective. The activities, through overall approach, training and technical assistance supported one another, and moved together in the direction of improving access and services for underserved segments of the population – especially youth. In areas of quality, sustainability and monitoring and evaluation, SEATS worked with both individual subprojects and with the collective of Zambia program activities to assure consistency in approach and to foster the utilization and replication of successful models to the greatest extent possible. Themes such as community involvement and mobilization, client-oriented services, supportive supervision and trainee follow-up were woven throughout the program. The overlap between subprojects served to increase the level of success experienced by each, and enhanced the potential for sustainability of effective models and approaches to service expansion and improvement.

A. Expansion of Family Planning Services in Lusaka Urban District

This subproject, initiated in 1996, was designed to work with the City Health Department, operating as the Lusaka District Health Management Team (LDHMT), to develop and strengthen the human resources and systems needed to support increased access to high-quality services in seven Lusaka clinics. Five subproject objectives were defined. The activities designed to achieve these objectives included training, clinic improvements, integration, quality improvement and expansion of method mix. The objectives, with their associated activities and outputs, are summarized below:

Objective 1: To train a core of 45 service providers in the delivery of high-quality family planning services (including 14 providers trained in IUD insertion); and provide training for 20 MCH supervisors from Lusaka City.

- A standardized, four-week competency-based FP curriculum was developed with input from the General Nursing Council and other organizations. The course emphasized method contraindications, client counseling, physical examinations, infection control and a syndromic approach to sexually transmitted infection (STI) screening and management.
- 36 providers and 4 supervisors were trained (20 anticipated supervisors were not available for training; and many were later trained under the CARE/CPF program) using the curriculum.
- 15 providers were trained in IUD insertion and removal.

- Trainee Follow-up (TFU) tools were developed in collaboration with the ZFPS Project. Previously trained service providers were assessed for skill retention in client counseling, history taking and physical examination. The first assessment carried out two years post-training showed an estimated 55 percent skill retention. Corrective feedback and revisions in training led to end of project findings of 70 percent skill retention.
- Clients were also reported to be satisfied with the FP services provided, as measured by client exit interviews.

Objective 2: To provide long-term and permanent methods of contraception, including IUDs and injectables at all subproject clinics.

- The 15 providers trained in IUD insertion (above) received additional on-the-job (OTJ) training in IUD insertion/removal. There were 705 IUD insertions during the course of the project.
- 14 providers (2 per subproject clinic) were trained in interpersonal communications and counseling (IPCC). A referral system was developed during this workshop conducted by ZFPS.

Objective 3: To increase referrals for NORPLANT® and VSC (primarily female) from a baseline of zero to 25 percent of all (CYP) generated by project clinics.

- Lusaka was able to substantially increase the number of referrals for permanent and long-term methods. In the first two quarters of the project, there were no referrals, and by Q4/98 the total CYP generated by referrals was 12 percent of the total, with over 300 clients referred for IUD, VSC and NORPLANT®. Although this is short of the goal of 25 percent of all CYP generated from referrals, it is expected that this proportion will increase in the future.

Objective 4: To achieve an average 30 percent annual increase in CYP from a starting point of 2,000 (1996) to a total of 10,400 CYP for the three years of the subproject.

- 4,477 CYP were generated in PY1.
- 6,373 CYP were generated in PY2.
- 6,221 CYP were generated in PY3 (an increase of 28%)
- Total CYP was 17,071. Table 1 shows the CYP increase as well as new users and revisits throughout the life of the project. Overall, the subproject surpassed its expected service delivery outputs by a wide margin.

Table 1. Lusaka Service Statistics Summary

Quarter	New Users	Revisits	CYP
2/96	1,939	4,889	1,303
3/96	868	2,039	526
4/96	1,828	7,039	1,157
1/97	1,974	4,258	1,491
2/97	2,290	5,250	1,723
3/97	1,230	4,246	1,242
4/97	2,041	5,282	1,692
1/98	1,761	6,459	1,716
2/98	2,334	7,664	1,632
3/98	2,326	8,535	1,694
4/98	1,546	5,877	1,619
1/99	1,237	7,497	1,276
TOTAL	**21,374**	**69,005**	**17,071**

Objective 5: To improve quality of care (by complementing method-mix expansion and clinical training) through increased and improved supervision and organization of FP services and by creating a supportive clinic environment.

- Quarterly review and feedback meetings were held at subproject sites.
- Equipment and consumable supplies were provided to seven health centers.
- 67 additional staff were oriented to FP, including nurses, midwives, clinical officers, nutrition demonstrators, clerks and community health workers.
- 25 logistics management staff were trained; a "pull" system was established in collaboration with the JSI-implemented Family Planning Logistics Management (FPLM) Project. The "pull" system allows providers to make forecasts for contraceptive commodities and place orders based on anticipated needs. Previously, contraceptives were "pushed" from the district level, regardless of the needs of health centers. The "pull" system has reduced stock-outs at the health centers.
- 53 staff and community members were trained in Continuous Quality Improvement (CQI) and Youth-Friendly Health Services (YFHS). Subsequently, Health Center Quality Teams were formed and taught to use CQI tools including the Decision-Making Matrix, the Cause and Effect Diagram and the Process Flow Chart.
- Clinics were refurbished/renovated.
- A 3-day MIS workshop was held for 25 service providers to enhance their management skills and enable them to more effectively monitor services.

The outcomes of these activities and outputs include increased contraceptive prevalence rates (i.e., based on CYP figures); increased client satisfaction with services (i.e., increase in clinic attendance shown by quarterly statistics); and

increased/improved method mix (i.e., an increase from three to eight methods offered). These are further discussed in the next section (VI. Accomplishments).

Although midway through the subproject most of the subproject objectives had been met, there were serious constraints encountered, which both hindered progress and led to revision of some of the anticipated targets and activities. These included:

- Significant turnover of trained staff due to the health reform, increasing the workload of remaining staff and compromising the quality of service delivery;
- Low morale and motivation of staff caused by the on-going staff delinkage exercise;
- Re-deployment of staff following training, sometimes to health centers without adequate facilities to utilize training, resulting in a loss of newly acquired skills;
- An existing referral system which did not allow for appropriate tracking and follow-up of clients by the referring provider;
- Stock-outs of contraceptives and supplies prior to implementation of the "pull" system due to improper forecasting and shortages at the district level;
- Inadequate space for the provision of quality services in some clinics, and delayed renovations due to prolonged contracting procedures.

During a midterm evaluation of the subproject conducted in early 1998, a number of recommendations were made to address these problems and constraints. It was suggested, for example, that the district budget for further training that might be required; that the sale of contraceptives be considered; that the logistics system be reviewed and revised; and that the referral system be reviewed and revised. The project manager tracked progress on efforts to address these recommendations, and many were acted upon during the remaining year of subproject implementation. By the end of the project, the district had already started budgeting for some of the needed health center training, and, in fact, co-funded some training provided by SEATS. Supplies were monitored quarterly and stock-outs were reduced as the commodities "pull" system was instituted. The district also began providing some of the commodities used by the health centers, such as gloves and other consumable supplies. Significant work remains, however, to assure the continuation of sustainable, high-quality service delivery in the subproject health centers.

In April of this year, an end-of-project dissemination meeting was held in Lusaka, chaired by the Acting Director of the LDHMT. The meeting was attended by representatives from the LDHMT, SEATS, the subproject health center staff, community, youth and collaborating agencies. A discussion of the project's objectives, accomplishments and constraints was undertaken; and recommendations and suggestions were set forth for the continuation and sustainability of activities. Recommendations included that fund raising mechanisms be developed to support peer educators; that the District Health

Management Team (DHMT) create a revolving fund for peer educators; and that sustainability activities be included from the outset of any project.

Appendix I includes a complete list of references and documents which provide details on all aspects of the design, implementation and evaluation of this subproject.

B. Lusaka Urban Youth

The LDHMT has identified adolescents as a priority underserved population, and USAID/Zambia's HPN office has designated an integrated adolescent package as its top priority. As a result of information from participatory research conducted in Lusaka by CARE (March 1996), and confirmed by SEATS' mini PLA exercise, the LDHMT noted poor knowledge of RH and sexual health, very early onset of sexual activity, significant increases in unwanted pregnancies, high rates of STI (including HIV) and high rates of septic abortion among young people. Structured evaluation of youth programs has been lacking, resulting in very little knowledge about effective models for providing information and services to youth in Zambia.

SEATS' 18-month Lusaka Urban Youth subproject focused on improving the provision of RH services to youth aged 12-24 years by undertaking rapid assessment exercises and research to determine effective strategies for delivering services.

By working with the public sector, and applying research methods to test models of youth service delivery, SEATS and the LDHMT aimed to identify approaches which can be incorporated into existing service structures. The subproject was designed to support the provision of improved RH services to youth in seven high-volume urban clinics (the same clinics participating in the Lusaka Urban Subproject) and their catchment areas, with particular focus on documenting and evaluating a model approach at two clinics (Matero Reference and Bauleni). Extensive collaboration, particularly with CARE and UNICEF, was implicit in this subproject.

The following objectives and outputs were realized through strategies based on advocacy and community mobilization; development of youth-friendly clinical, counseling and educational services; peer outreach and networking:

Objective 1: Create a supportive environment for the provision of adolescent reproductive health information and services in SEATS' seven project catchment areas.

- A Youth Project Coordinating Committee was established including the LDHMT, SEATS, the health center in-charge, the neighborhood health committee (NHC), quality of care (QOC) focal persons and youth.
- Youth Corners in two health centers were furnished and equipped.
- Mini-PLA dissemination was held, involving all stakeholders who took part in focus groups. Most of the activities implemented under the subproject were supported by findings from the mini-PLA exercise.
- 32 service providers were trained in youth-friendly integrated RH care (including providers from all seven SEATS-supported clinics and providers from CARE and ZFPS clinics).

- 20 peer educators were trained in RH and information sharing to work with the health staff in the Youth Corners of two pilot centers and conduct outreach activities in the catchment areas served by these health centers.
- Two refresher courses were held for peer educators.
- Peer educators worked conducting outreach, distributing more than 42,000 condoms and more than 14,000 foaming tablets, referring cases with STIs and unwanted pregnancies to health centers. Table 2 provides a summary of peer promoter activities, including group and individual contacts achieved.

Table 2. Total of Peer Educator Activities (Group and Individual Contacts)

	YOUTH REACHED				COMMODITIES		CONTACTS	
	Male	Female	Total	Referred	Condoms	Foam	New	Old
	545	961	1,506	138	4,502	340	651	270
Q2/98	1,612	3,874	5,486	1,034	10,476	1,484	1,921	2,235
Q3/98	1,461	3,240	4,701	1,976	5,709	3,435	2,095	2,625
Q4/98	1,417	2,305	3,722	120	11,628	4,068	1,731	2,139
Q1/99	810	1,992	2,802	832	10,499	5,260	1,499	1,303
Total	**5,845**	**12,372**	**18,217**	**4,100**	**42,814**	**14,587**	**7,897**	**8,572**

- 26 youth anti-AIDS club members from schools near centers were oriented to youth RH issues.
- A one-day community/parents mobilization meeting was held in each health center – involving NHC members, SEATS, the LDHMT – resulting in action plans to advocate for parents' support for utilizing YFHS.
- Sharing of experiences in community mobilization activities by the NHC chairperson and the clinic in-charge was included in quarterly coordination meetings.
- 53 service providers, NHC chairpersons and youth from all seven health centers were trained in CQI and YFHS – followed by development of action plans to improve provision of YFHS in both the centers and the community. Endline data show that youth-friendly corners in the clinics are viewed by youth as the most reliable source of FP/RH information.

Objective 2: Using pre- and post-intervention surveys, ensure that youth demonstrate increased knowledge of RH and sexuality.

- A mini-PLA exercise was carried out in October 1997. Youth involved in focus group discussions (FGD) expressed ignorance on the relationship between STIs and RH. With "friends" cited as the most prominent source of information on RH, and early initiation of sexual activity (12-15 for males; 10-14 for females), youth indicated that they need more and

better information, especially with regard to HIV/AIDS. Youth believed STI clients could only receive treatment at clinics if they came with partners.

- A community-based study by the FOCUS Project carried out in the catchment areas around SEATS-supported facilities at the mid-point of the subproject showed that approximately 20 percent of males and 15 percent of females age 10-24 had contact with peer educators. The topics they discussed included for females: HIV/AIDS – 70 percent, STDs – 35 percent, FP – 50 percent; and for males: HIV/AIDS – 75 percent, STDs – 40 percent, FP – 30 percent

Objective 3: Increase youth utilization of available RH services in the SEATS supported clinics by 30 percent above baseline levels.

- Baseline data indicated few youth sought treatment for STIs and few appeared for early antenatal care. Rapid assessment prior to the PLA showed low turnout of youth for counseling, averaging one client every one to two days. Out of every 10 who asked about STIs, only 1-2 were referred for services. FGD participants stated that clinics were the last place youth went when infected with STIs. First they would approach traditional healers or private practitioners. Antenatal care at clinics was avoided because girls were shy, clinics offered little or no privacy and there was a lack of gender balance in providers. The last quarter of the subproject (January - March 1999) show 468 youth treated for STIs; 836 registered for early antenatal care; and 28 referred for abortion complications. Table 3 shows the changes in the number of youth seeking these services over the course of the project, with a substantial increase from the first quarter of 1998 to the first quarter of 1999 – the period during which the project was in full implementation.

- On average, 50 youth per month utilized FP services in the seven subproject sites.

Table 3. Changes in the Number of Youth Seeking Services

	STIs (10-19 years)			# of ANC Cases (<20years)	Abortion Complications (12-24 years)
	Male	Female	TOTAL		
Q1/98	81	126	207	650	9
Q2/98	345	355	705	464	15
Q3/98	198	160	358	239	5
Q4/98	760	775	1535	1937	43
Q1/99	247	221	468	836	28

Objective 4: Enable non-sexually active youth at the two model clinics and respective catchment areas to delay first intercourse.

- Peer education and sharing of RH information occurred at the Youth Corners, in school drama performances and in outreach sessions with the community – including messages geared toward delaying first intercourse and encouraging those who have already become sexually active to act responsibly. Over the course of five quarters, as many as 18,217 youth were reached through both individual counseling and group educational activities. The short duration of the subproject, however, was insufficient to affect or verify behavior change relative to the onset of sexual activity.

Outcomes from these youth objectives and activities, including improved RH practices of youth, are discussed in the next section (VI. Accomplishments).

The Lusaka Urban Youth subproject was subject to many of the same constraints already described: a nationwide ban on workshops resulting in delays and reductions in the number and types of training activities anticipated and the number of participants; transfers of providers trained in youth-friendly service delivery; lengthy clinic renovations; and concerns of peer educators about lack of monthly allowances as a possible threat to sustainability. While the approach of using peer educators has proven effective in increasing access to and quality of services and information for youth, the question of remuneration for these "volunteers" may eventually jeopardize the program.

Appendix I includes a complete list of references and documents which provide details on all aspects of the design, implementation and evaluation of this subproject.

C. Zambia Nurses Association (ZNA)/Midwifery Association Partnerships for Sustainability (MAPS) Subproject

The SEATS MAPS Special Initiative targets nurses and midwives in both the public and private sectors. One of its primary objectives is to create regional linkages for nurses and midwives in order to improve service delivery and strengthen professional associations through the sharing of resources and experience. The American College of Nurse-Midwives (ACNM), the SEATS partner responsible for implementing this initiative, has been working in Zambia through the JSI-implemented MotherCare Project in collaboration with CARE and the Zambia Nurses Association (ZNA). Under MotherCare, ACNM developed the curriculum that CARE used to train nurses and midwives in youth-friendly RH services. This curriculum, the Primary Health Provider (PHP) curriculum and experienced

trainers provided the basis for training selected service providers in the seven SEATS-assisted clinics under the ZNA/MAPS subproject.

Strengthening ZNA's institutional capabilities through strategic planning and support for member services was ultimately intended to help ZNA contribute to meeting the needs of Zambian youth. The continuing education (CE)/training of ZNA members as both trainers and providers of youth-friendly services was the strategy designed and employed by ZNA to reach nurses and midwives beyond Lusaka, improving their ability to serve youth.

The objectives and outputs of the ZNA/MAPS subproject follow:

Objective 1: Establish a nurses and midwives regional network for mutual problem solving and sharing of resources and experiences to promote greater FP/RHC service delivery.

- A 3-day Regional MAPS workshop was held in Harare with 13 Zambian participants attending. Participants were provided with resources and contacts for other midwifery associations around the world as well as multi-lateral contacts.

Objective 2: Promote nursing/midwifery involvement in STI/HIV prevention for youth at the community level.

- Modules were developed for facilitators to conduct continuing education and update sessions at ZNA branches. Contents were derived from the national PHP curriculum.

- 27 ZNA members were trained in conducting continuing education, including facilitation skills to conduct YFHS updates. Trainees developed workplans for disseminating information and conducting CE/updates using eight training packages. Each provincial representative was also provided with an overhead projector and screen, pelvic and breast models, books on FP and videotapes. The materials are borrowed by branch chairpersons and used for CE sessions.

- 22 out of 27 trained facilitators submitted "update session" reports, indicating over 500 nurses and midwives reached. One facilitator engaged assistance from a clinical FP trainer to co-facilitate a CE session.

- More than 200 nurse-midwives participate in update sessions on a repeat basis.

- Follow-up supervision carried out on a sample of facilitators conducting update sessions and focus group discussions with nurse-midwives resulted in revision of specific modules.

- Follow-up study at 14 sites with trained nurses showed that 11 out of 14 had institutionalized youth friendly services; and that the nurses' knowledge of YFS had increased substantially since training.

- At the refresher for CE facilitators, an additional 20 ZNA members with the potential to conduct update sessions were recruited and provided with knowledge and skills to facilitate sessions, increasing the total number of facilitators to 47.

Objective 3: Train selected service providers as trainers in youth-friendly RHC approaches.

- Youth-Friendly components were included in Primary Health Providers Training Modules 3&4 used to train ZNA CE facilitators.

- Two ZNA members were trained in facilitation skills (in lieu of an 18-day training of trainers (TOT) and CE course for 60 nurses and midwives which was cancelled due to the training ban).

- Due to the ongoing ban on workshops, a planned Youth Conference could not be held, but was replaced by four one-day Youth Meetings at four provincial sites, reaching more than 80 nurse-midwives. The meetings described the nurse-midwives' role and potential activities in YFHS, and included suggestions to promote services for youth in ZNA's strategic plan. At each meeting, nurse-midwives prepared action plans to promote services for youth and identify resources needed.

- Youth-friendly CE updates were conducted at each meeting of 20 ZNA branches.

Objective 4: Expand and/or build selected membership services to increase ZNA's capacity for sustainability.

- A five-day leadership workshop was held for 18 ZNA management staff, which included development of a two-year strategic plan for ZNA and plans for sustainability, strengthening and expanding services, and to develop a FP/HIV CE proposal. Following the workshop, three new branches of ZNA were opened.

- A full-time project coordinator was hired and an office established at ZNA headquarters.

- Sustainability and Quality action plans were developed and implemented, including output indicators.

- A membership survey sampled 40 branches (19 responded). It identified needs for improved services and continuing education opportunities.

- ZNA communication and other functions were enhanced with computer, email and a fax machine.

- A computerized ZNA membership database was developed and installed.

- The ZNA newsletter was revived to share information and advise members of CE opportunities. A sample newsletter is included in Appendix II.

- Quarterly planning and review meetings were held at the national and branch levels.

- Membership recruitment is underway, including member fee/dues collection efforts.

- A ZNA strategic business plan is being developed and updated.

- A project proposal for a privately owned ZNA clinic was written. Leveraging for funds is underway.

Objective 5: Assist ZNA in creating a more enabling environment for private nurse-midwifery practice in Zambia through sharing of experiences with other regional MAPS activities targeting private sector midwives.

- 13 ZNA members participated in a three-day regional private practice workshop was held in Harare immediately following the MAPS dissemination conference.

As a regional Special Initiative, MAPS subprojects benefit from support both in-country and from SEATS regional headquarters and international resources – including technical assistance, information sharing and training. Some constraints still hampered complete satisfactory implementation of the ZNA/MAPS program plans. Health reform bans on training precluded ZNA/MAPS from implementing all of the training needed to foster support and adequate technical knowledge and skills to increase and improve reproductive health care, especially for youth. With these services being relatively new, the lack of rigorous training support threatens their sustainability. There is also a notable lack of adequate teaching and IEC materials. Emergence of a cholera outbreak led to significant delays in the implementation of action plans for some ZNA facilitators. These factors all presented obstacles to the desired initiation of YFHS by ZNA.

Although ZNA is making great strides in increasing its membership and expanding member services, the ability to collect member fees/dues has not kept pace. This could ultimately threaten the quantity and quality of services available to members, and trigger a downward spiral in the organization's membership rolls.

Appendix I includes a complete list of references and documents which provide details on all aspects of the design, implementation and evaluation of this subproject.

D. Reproductive Health Integration Initiative (RHII)/SEATS Performance Result 2 Site: World Vision/Zamtan

SEATS developed the Reproductive Health Integration Initiative (RHII) in 1995 to assist both health and non-health related NGOs and PVOs to integrate RH into their existing program portfolios, an approach reflecting the SEATS II strategy for working with under-utilized resources to provide services to underserved populations. With the SEATS II Contract Modification in 1998, one of the new Performance Results (PR2) redirected the RHII to more rigorously address PVO capacity to design, deliver, sustain, monitor and evaluate quality RH programs. Under PR2, three PVO sites were selected and supported to improve their RH program capabilities. In collaboration with USAID/Zambia and the ZFPS Project, SEATS selected World Vision/Zamtan as one of the sites. While PR2 efforts were concentrated on the WV/Zamtan Project, SEATS included staff from WV health

projects in Lufwanyama and Gwembe and the national office in Lusaka in training and technical assistance efforts. Further, at the request of USAID/Zambia, SEATS also included other NGOs supported through the ZFPS Project in training and technical assistance activities in order to strengthen their programs and capabilities. These efforts were led by Initiatives, Inc., the SEATS partner responsible for implementation of the RHII.

With funding from ZFPS, World Vision has been implementing the Zamtan Family Planning Project since June 1997. The objective of the project is to increase the contraceptive prevalence rate from 15 to 50 percent in two years, through the training and deployment of 20 community-based distribution (CBD) agents. SEATS provided assistance in the areas of monitoring and evaluation, quality of care and sustainability through a series of project monitoring visits, workshops and follow-up technical assistance.

The operational objectives and outputs of the World Vision (WV)/SEATS collaboration were:

Objective 1: Strengthen supervision and project management.

- A six-day workshop was held for approximately 24 WV and other NGO supervisors and program managers. A training emphasis on client follow-up as opposed to just the recruitment of new clients contributed to the increase from 45 to 72 percent of continuing client follow-up.

Objective 2: Improve and support WV sustainability activities.

- SEATS conducted a sustainability planning workshop for 26 staff from WV and other PVOs.

- A consultant provided follow-up technical assistance in implementing sustainability plans.

Objective 3: Maintain and strengthen World Vision's RH program quality.

- A two-day quality workshop with 28 participants was held to focus on strengthening quality elements identified during reviews, and included preparation of a Quality Plan.

- Joint SEATS/WV progress reviews were held semi-annually to document changes in program and service quality using the Program Improvement Review (PIR) Package designed by Initiatives, Inc. for SEATS. The need to address CBD knowledge and presentation skills identified at one of the performance reviews allowed WV to develop interventions which increased CBD knowledge from 25 to 74 percent (based on data from the PIR).

Objective 4: Strengthen WV monitoring and evaluation capacity and implementation.

- WV program staff were trained to utilize (and adapt for specific program needs) the Program Implementation Review (PIR) Package.

- A community-based survey design consultation and workshop conducted by SEATS for 32 participants helped WV learn various methods of evaluation and research through direct experience (other NGOs were included in the workshop).

- A community survey was implemented.

- A progress review and evaluation were planned for the end of the project.

Unlike Zambia's public sector programs, PVOs and NGOs are not faced with the constraints of health sector reform training bans and staff delinkage. However, these organizations face a separate set of challenges and issues. Staff are often stretched among diverse program responsibilities, and organizations' leadership may lack the technical expertise needed to adequately oversee FP or RH interventions and actions. WV-supported CBD agents are supplied with contraceptives through government distribution systems and are, therefore, subject to the logistics management problems faced throughout the National Family Planning Program. Significant effort must be made to ensure appropriate coordination between PVOs and public officials and programs. This has not presented a problem under the WV activities, as the DHMT has participated consistently in program monitoring and quality review exercises, and WV collaborates effectively with the GRZ.

Documents related to the World Vision/Integration Initiative activities and SEATS integration efforts are listed in Appendix I.

E. Participation in Regional Activities

Throughout the life of the project, SEATS has conducted numerous regional activities to serve the needs of leaders and service providers from multiple countries. SEATS technical staff from central, regional and country offices have conducted these events. With SEATS support, Zambian public and private sector personnel have participated in these activities as follows:

- MAPS Dissemination Conference (Harare, Zimbabwe) – 13 Zambians participated in the 2-day conference in June, 1999, which highlighted successes and reviewed lessons learned during the five years of the MAPS Initiative. Participants included USAID, WHO/Geneva and other donors, as well as government officials, collaborating agency (CA) representatives and midwives from Zambia, Zimbabwe, Uganda, Tanzania, Eritrea and Cambodia.

- MAPS Regional Workshop (Harare, Zimbabwe) – 13 Zambians participated in the 3-day workshop in June, 1999. The workshop focused on the role of the midwives' professional associations in facilitating the members' provision of FP/RHC services.

- Quality and Sustainability Workshop (Harare, Zimbabwe) – Two project managers attended a one-week workshop which reviewed key concepts and elements of quality and sustainability. Participants discovered tools to identify critical issues impacting quality and sustainability and monitor improvements. Participants developed plans to form quality and

sustainability teams and to develop quality and sustainability action plans for their organizations.

- Sustainability Workshop (Ivory Coast) – Two Zambians (a project manager and the ZNA treasurer) attended. SEATS sponsored the participation of its NGO partners in a sustainability workshop conducted by the Institute for Development Research (IDR) and OIC International. More than 200 delegates from Africa participated.

- Quality/Monitoring and Evaluation Workshop (Harare, Zimbabwe) – Two project managers attended. The CQI/M&E workshop represented in large part an effort to improve linkages between CQI and M&E, and to strengthen the evaluation of quality of care in SEATS II subprojects. In addition to providing a refresher or new exposure to CQI techniques, it also emphasized the need for each quality action plan to have an M&E component with measurable objectives, appropriate indicators linked to each objective and appropriate data sources for the measurement of each indicator.

- Technical Exchanges (MAPS) – Two midwives from Zambia were sent to Gweru, Zimbabwe and two midwives from Uganda were sent to Lusaka, Zambia to see private practice and youth-friendly services. Two Zambian midwives were sent to Uganda to visit the Uganda Private Midwives Association polyclinic.

- Regional Urban Study Dissemination (Harare, Zimbabwe) – Two Zambians attended. The conference aimed to develop a "new vision for urban family planning programs in sub-Saharan Africa." Ideas and proposals from this meeting led to the development of the SEATS II Urban Initiative.

- Integration Workshop (Harare, Zimbabwe) – Four Zambians (two WV health coordinators and the YMCA Executive Director and PHC Coordinator) attended the first workshop and field test of SEATS' integration handbook: Integrating Reproductive Health into NGO Programs Volume 1: Family Planning, in June 1996.

- Child Survival PVOs Integration Workshop (Mangochi, Malawi) – Four Zambians from USAID/W-supported Child Survival PVO programs attended the second Africa Integration Workshop using the Integrating Reproductive Health into NGO Programs Volume 1: Family Planning, in September/October 1997.

- Study Tours – Four Zambians (two peer educators, two youth supervisors) visited youth groups in and around Johannesburg, South Africa. The focus was on sustainability of activities and on the services the groups were providing.

- Leveraging and Proposal Writing Workshop (Harare, Zimbabwe) – Six Zambians attended. SEATS designed and conducted a workshop on leveraging resources for reproductive health. The 10-day workshop had two objectives: to facilitate the development of leveraging strategies by participating organizations and to contribute to the development of the SEATS leveraging guide. Representatives from seven SEATS partner organizations in southern and eastern Africa participated. Each produced an action plan for leveraging resources to support their identified needs.

- Technical Assistance – backstoppers and technical staff from ARO and SEATS headquarters provided ongoing, targeted TA to the Zambian program.

Following participation in regional activities, quality and sustainability plans were developed for each SEATS subproject or activity in Zambia. They included additional in-country training. Quality teams have been formed at each of the SEATS-supported health centers, and some trained staff began to develop funding proposals for needs identified in their centers.

VI. ACCOMPLISHMENTS

The previous section (V – Implementation) outlines very briefly what SEATS has done in collaboration with many partners in Zambia; and Appendix I offers an extensive list of documents providing details on each activity. It is important, however, to consider what overall contributions SEATS II has made to Zambia's national FP and RH programs and what value SEATS has added toward the achievement of USAID's SO and sector goals.

A. Improved Access to RH Services

SEATS activities were designed to focus primarily on seven health centers in Lusaka District and their surrounding catchment areas. Significant renovations to these clinics were undertaken, with equipment and materials supplied by SEATS in order to increase access to needed services for the population as a whole. The creation of Youth Corners in model clinics provided a designated space where youth, specifically, could come and, with reduced obstacles and barriers, receive specialized RH services and information. These contributions to YFHS were essential in expanding access for the population deemed most in need and had an influence beyond the youth subproject. On follow-up of ZNA nurse-midwives who had developed action plans during youth meetings, for example, eight were found to have developed operational Youth Corners.

Chart 1 below, shows the number of new acceptors/new users by method served in the SEATS-supported clinics over the life of the Lusaka Urban and Lusaka Youth subprojects.

Chart 1. Lusaka Urban and Youth New Users by Quarter

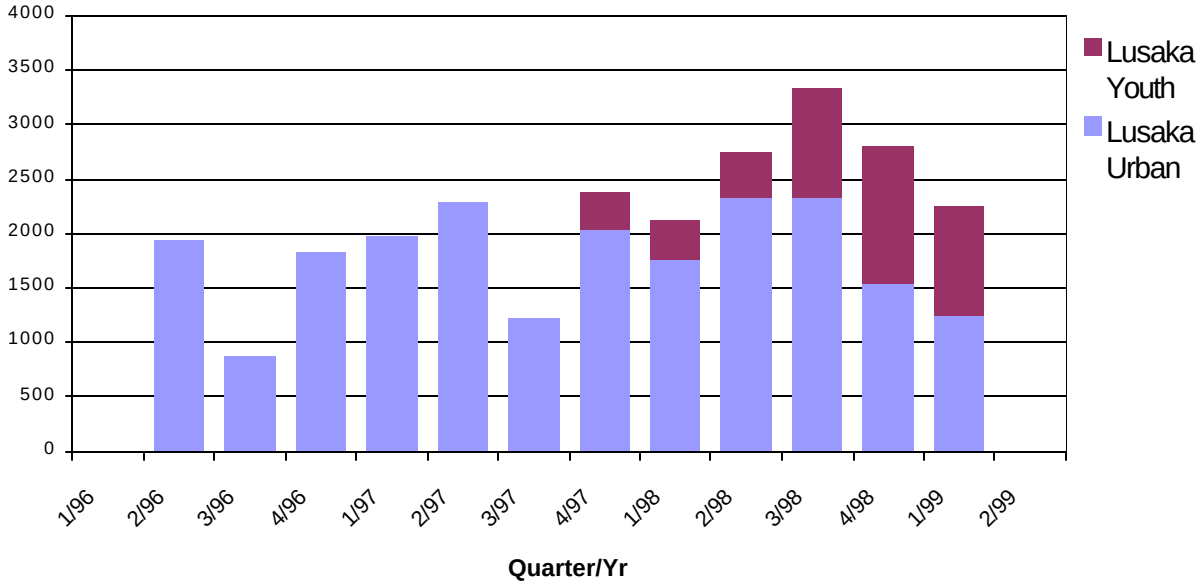


Chart 2. Lusaka Urban and Youth Revisits by Quarter

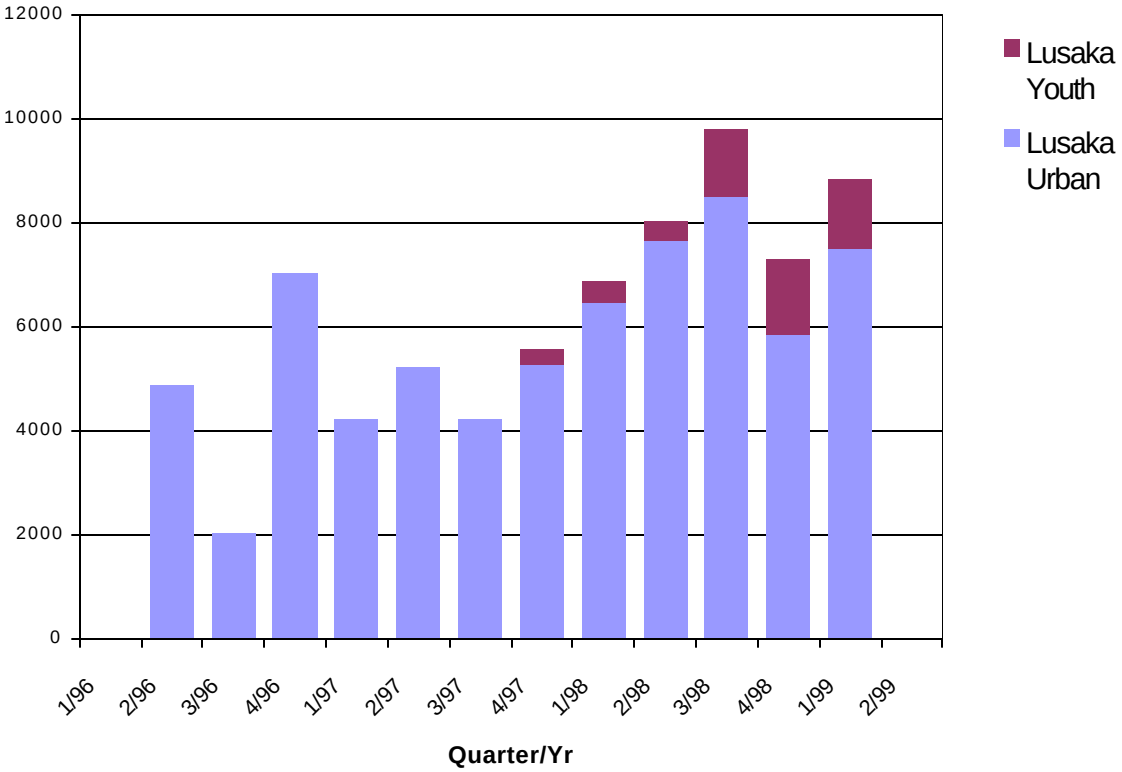
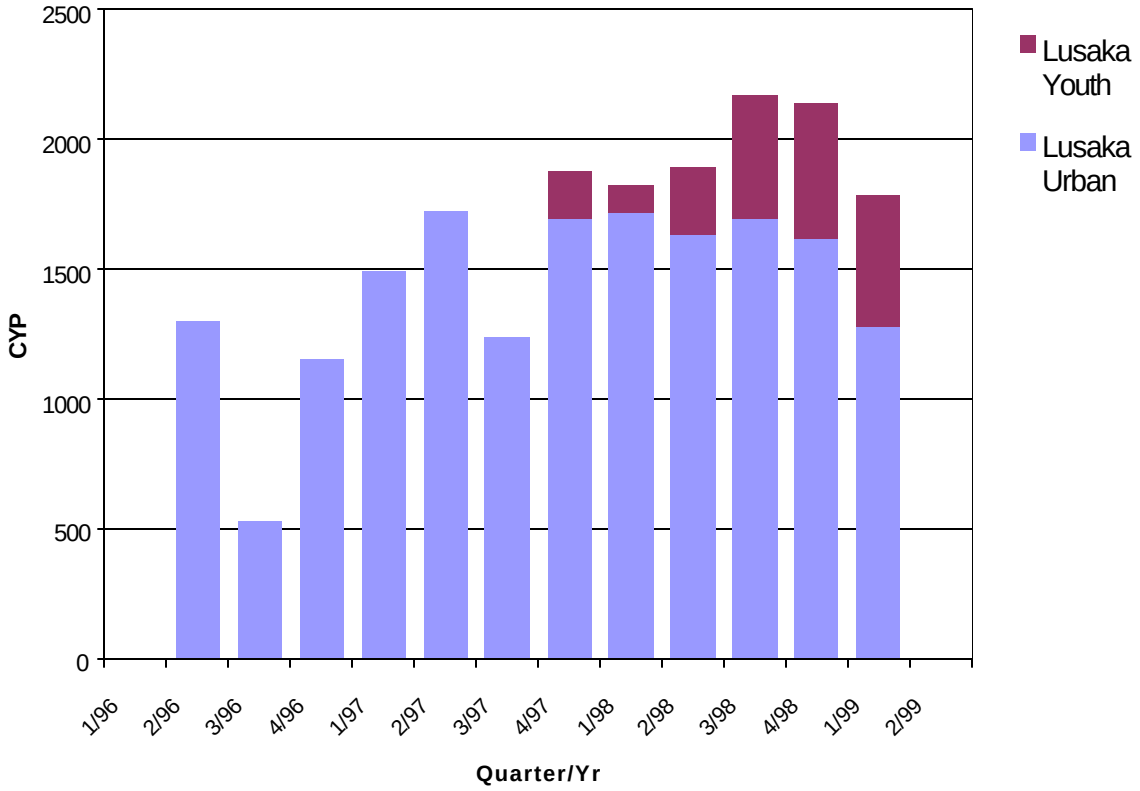


Chart 2 shows revisits to the clinics and Chart 3 shows CYP from the same two subprojects. The charts show an overall upward trend in services provided,

especially to youth, through the seven clinics supported by SEATS. The total CYP provided through these clinics from February 1996 through January 1999 was almost 21,000.

Chart 3. Lusaka Urban and Youth CYP by Quarter



An important aspect of improving access rests in the changed attitudes and role of the Neighborhood Health Committees. As documented in mini-PLA interviews, prior to SEATS facilitation, the NHCs were, in general, unsupportive of FP and RH services being offered to youth. Through intensive community mobilization efforts, the NHCs have now become positive advocates for and supporters of increased access for youth. This change is reflected in post-project focus groups conducted under the follow-up mini-PLA.

FINDINGS OF THE PLA

Baseline:

- Youth were found to begin sex early, facing serious risks of unwanted pregnancy and STIs, including HIV/AIDS. In FGDs, the average age of initiation of sexual activity was thought to be around 12 years for boys and 10 for girls Many youth engaged in sex in exchange for money or gifts, often as their only source of income.
- Youth had very basic knowledge of contraception and STIs, but had many misconceptions. The main source of information was friends.
- Use of family planning clinics by youth was very low. Providers were viewed as antagonistic toward youth. Services were not considered to be "youth-friendly." The NHCs generally had negative attitudes toward providing youth with contraception.

Endline:

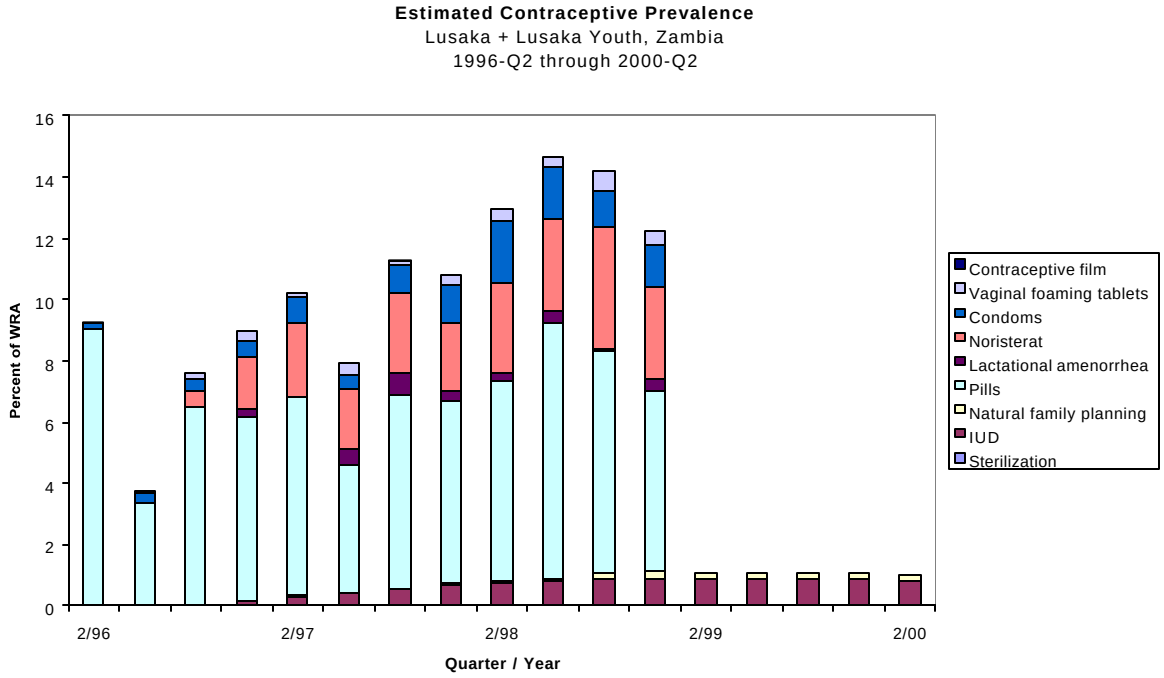
- Youth Corners were successfully established and heavily utilized by youth at the two model clinics of Matero and Bauleni.
- 20 peer educators were trained to provide information and some contraceptives at the Youth Corners, and to contact youth in the catchment areas around the model clinics.
- Nurses in five other SEATS supported clinics were trained in youth-friendly services.
- Exit interviews showed youth to be generally satisfied with the clinic services. Ninety percent said the nurse was polite, 95 percent said the peer educator was polite and 98 percent said the peer educator was able to address their problems/questions. Youth reported feeling more comfortable with and receiving better treatment from peer educators than from nurses. Nurses were still seen as being critical of sexual activity among youth (17 percent said the nurse criticized them for their behavior). Youth preferred Youth Corners to the main clinics in terms of privacy.
- In FGDs, youth rated peer educators as one of the most reliable sources of RH information.
- The NHCs demonstrated much more positive attitudes toward providing RH services to youth than in the baseline.
- Most youth attending the clinics are at least 19 years old and married (74 percent), but about a quarter of those served are young, never married, and without children.
- CYP was 2,067 between Q4/97 and Q1/99. During the same period 4,415 new users were served, and there were over 1,000 new youth users per quarter through all seven clinics by the end of the project. Between March 1998-1999, peer educators contacted 16,000 youths, referred 4,000 youth to clinics, and distributed over 39,000 condoms.
- Sustainability is a major issue. Many peer educators were unsatisfied with the incentives, saying that there were misunderstandings about whether incentives would be given, and in what form. There should also be a plan to train new peer educators as existing ones age out of the program. Despite these issues, 17 out of 20 peer educators remained active for the duration of the subproject.
- Youth continue to initiate sex at an early age, in large part due to increasing poverty. Youth and parents noted that youth, especially females, engage in sex in exchange for money or gifts, often with parental consent. Older men known as "sugar daddies" seek out young girls in the belief that they are AIDS-free.

Encouragement and approval of NHCs are essential in order for neighborhood youth to feel comfortable and responsible seeking services close to home.

The increase in service utilization is also reflected in increased CPR in the subproject catchment areas. This is reflected in Chart 4, below, as measured by SEATS' Family Planning Program Monitoring and Evaluation System (FPPMES).

While it is clear that many factors contribute to increases in service utilization and continuation, SEATS is pleased to have played a part in providing greater access and stimulating demand.

Chart 4. Estimated Contraceptive Prevalence



B. Improved Quality

Method Mix

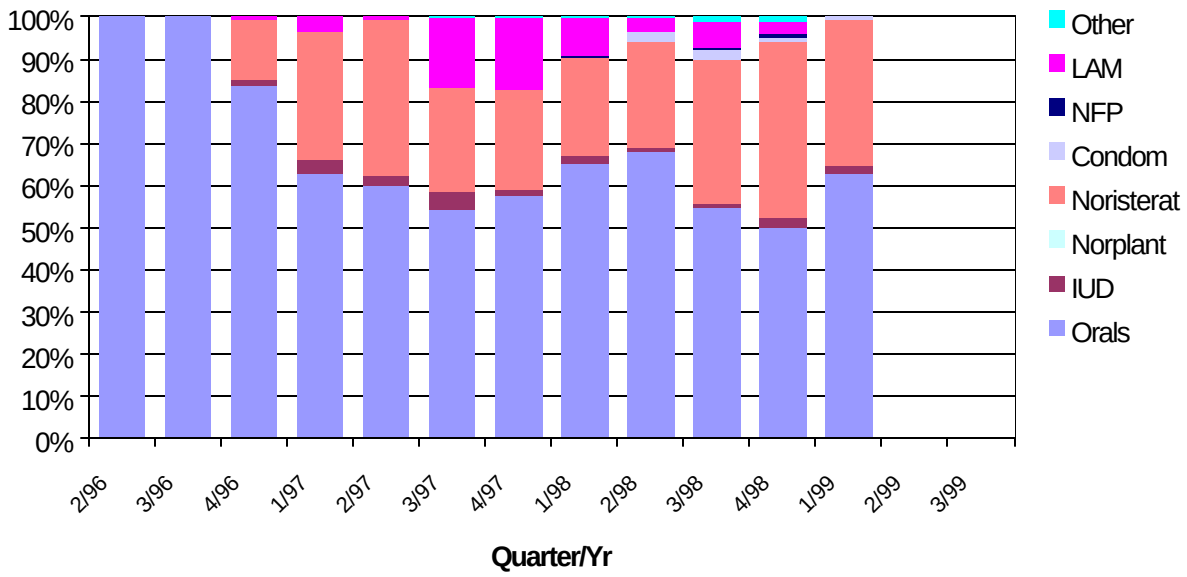
Having a range of family planning methods available is an important indicator of good service quality. From baselines showing nearly exclusive reliance on pills by new users, later service statistics reveal a better balance including condoms and foaming tablets in addition to orals and injectables – a balance which is more appropriate, especially for youth and the aim to prevent both pregnancy and sexually transmitted infections. Training in basic FP and specific methods, IPCC

training and improved logistics management all contributed to the expansion of method mix experienced under the project.

One year after the project's inception, the method mix in the SEATS-supported clinics had been expanded from three to eight methods. Service delivery points initially offering only condoms, foaming tablets and oral contraceptives were found to offer eight different FP methods. Clients were referred to UTH for VSC and to two CARE-supported clinics for NORPLANT®. In one year, referrals for long-term and permanent methods went from 0 to 106. At the end of the subproject, 102 clients had been referred for injectables (before their availability at the health centers), 171 for NORPLANT® and 112 for VSC.

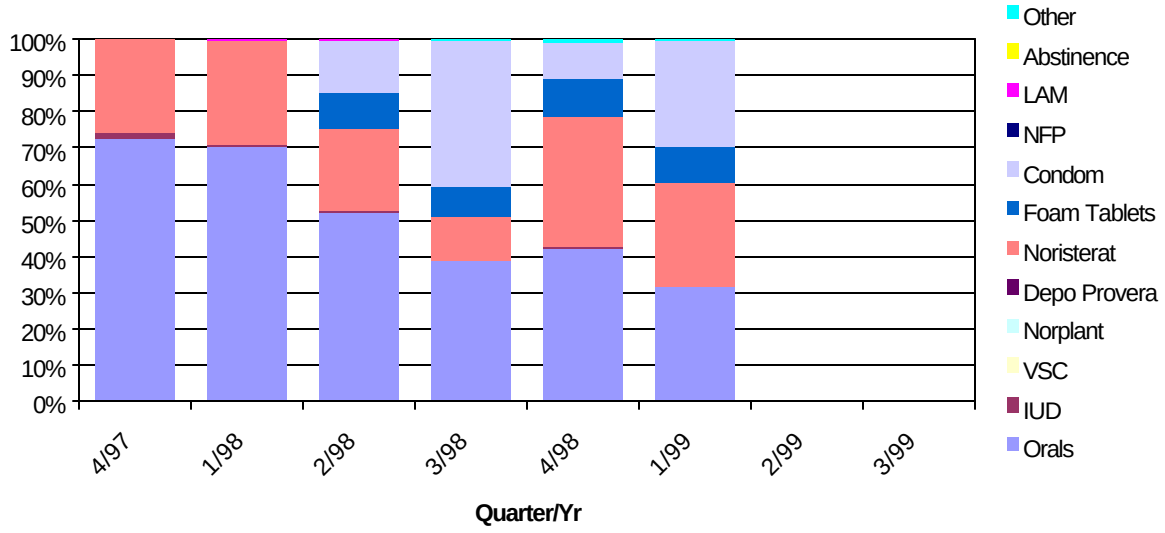
Charts 5 and 6 present figures from both the Lusaka Urban and the Youth subprojects reflecting this important change in method mix over time.

Chart 5. Lusaka Urban Method Mix by Quarter (New Users)



The improved method mix, particularly increased use of foaming tablets, may also indicate an increase in dual protection. The change in method mix could indicate improved reproductive health status for youth.

Chart 6. Lusaka Youth Method Mix by Quarter (New Users)



Youth Focus

Promoting and strengthening YFHS played a critical role in addressing the needs of this most needy segment of Zambia's population. Subproject activities that created a system for the recruitment, training and support of 20 peer educators were a major contribution to improved service quality for youth. Data from service statistics and the PLA exercise show that there has been a dramatic increase in utilization of services by youth. From baselines showing very little utilization by youth, latest service statistics reveal that 468 youth were treated for STIs; 836 registered for early antenatal care; and 28 were referred for abortion complications. On average, 50 youth per month utilized FP services in the 7 SEATS-supported sites. Their knowledge of RH issues and awareness of how to access services have improved; and they are more satisfied with the services they receive. Exit interviews and provider assessments undertaken post-project in four SEATS supported clinics showed that confidence in the clinic providers is very high – with 95 percent of respondents believing that both nurses and peer educators had the necessary skills to attend to their problems. Among youth asked to rate the friendliness of providers, 75 percent felt that the clinic nurses were hospitable to youth (nearly half stating that the nurses are friendly, while about one quarter said they are very friendly). Only a very small proportion (five percent) said the nurses' approach toward youth was not amicable. Peer educators were rated even higher, with 98 percent deemed polite and friendly.

The number of youth contacts made by peer educators is shown in Chart 7, while Chart 8 shows an impressive number of commodities distributed by the peer educators during slightly more than a year. Over time, the trend is toward increasing contraceptive use by youth.

Chart 7. Peer Educator Contacts

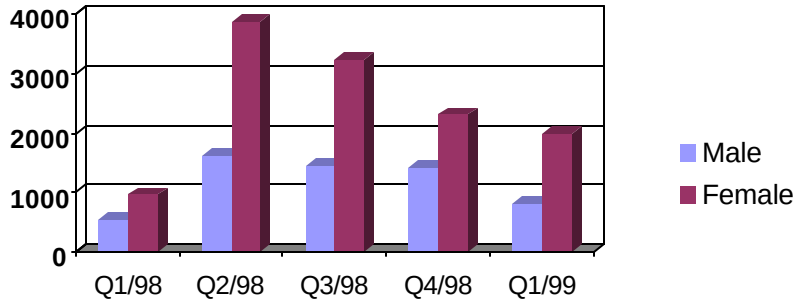
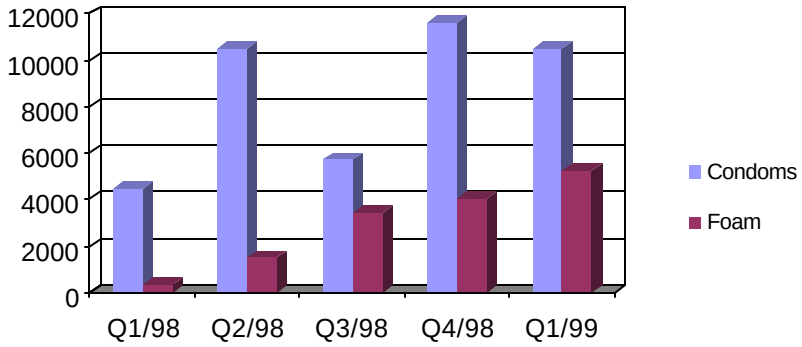


Chart 8. Peer Educator Commodities Distributed



Exit interviews and provider assessment along with a study by the FOCUS Project in selected facilities in Lusaka provide further evidence of improvements in service quality, particularly as they relate to serving youth. Such improvements include: positive experience in clinics; confidence in providers (both nurses and peer educators); promptness in attending to clients; comfort in talking to peer educators; convenience of receiving services – particularly in Youth Corners; and improved community outreach. Issues of confidentiality and privacy remain concerns to the youth interviewed. Almost all of the youth interviewed said that they would recommend the facility to their friends because of good medical attention, knowledge in FP and good services.

In the same clinics, YFHS-trained staff recognized the need for friendliness and privacy as well as high quality services. Nearly all interviewed staff felt they were not competent to handle all that is expected in YFHS provision – particularly in regard to counseling, and especially for HIV/AIDS. Staff, generally, would like to do more for youth.

Integration

Major strides in quality improvement in integrated PVO and NGO RH programs have been achieved with World Vision/Zamtan serving as the focal point for the development, field testing and adaptation of the Program Improvement Review (PIR) Package. WV, SEATS and the DHMT have conducted semi-annual and systematic joint program reviews using a process and instruments specially designed to examine elements of community based RH programs. Through these reviews, problems and challenges of integrating RH into existing PVO and NGO portfolios have been identified and addressed. A workshop and technical assistance to help strengthen supervision and project management led to a 27 percentage point increase (from 45 to 72 percent) in continuing client follow-up; and interventions to improve CBD knowledge and presentation skills resulted in an increase from 25 to 74 percent in their knowledge.

Continued utilization and adaptation of the PIR Package and its dissemination to other PVO/NGOs in Zambia, as well as its potential to be used in WV/PVO programs in other countries, constitute an important and growing contribution to RH program quality improvement.

Training/Human Resources Development

In support of the National Health Policy, all of the SEATS subprojects and Special Initiatives included elements of enhanced human resources development, ranging from training to regional workshops and continuing education for service providers to personnel management systems improvement. A trainee follow-up system applicable to all efforts to upgrade knowledge and skills revealed that the technical competence of service providers has been improved as a result of training and education activities supported by SEATS.

Rigorous and well-designed training is generally considered an effective approach to quality improvement, especially when coupled with careful follow-up monitoring and targeted technical assistance. Training bans triggered by health reform notwithstanding, SEATS designed and delivered an extensive amount and variety of training to Zambian service providers, program managers, community members, youth, government officials and organizational leaders through subprojects, Special Initiatives and regional activities.

The number of trainees and types of training/content areas provided by SEATS through the three primary subprojects are shown in Charts 9 to 11.

The figures above do not reflect:

1. the subsequent Continuing Education sessions offered to more than 500 nurse-midwives through the MAPS subproject,

2. integration training received through seven PVO/NGO training events attended by 144 participants (primarily Zambian PVO/NGO representatives both regionally and in country), or the training provided through SEATS regional workshops on quality, sustainability, monitoring and evaluation (discussed in Section V, above).

Chart 9. Lusaka Youth Training by Courses (N-185)

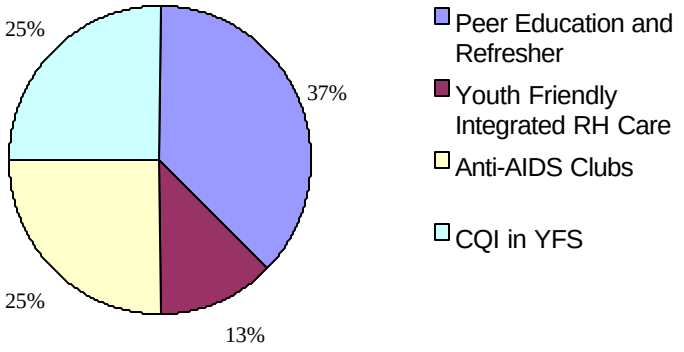


Chart 10. Zambia MAPS Training by Courses (N-185)

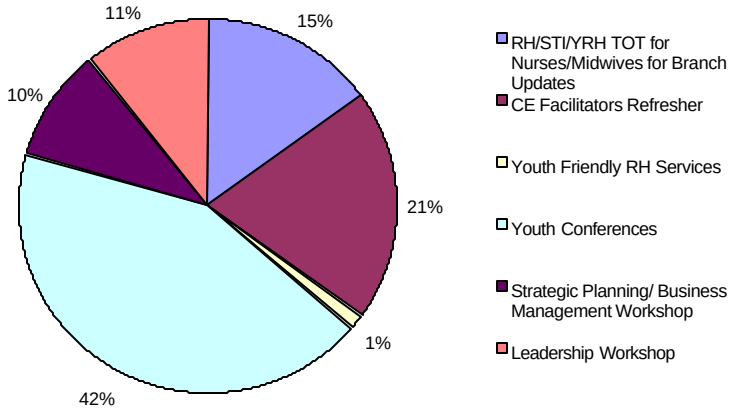
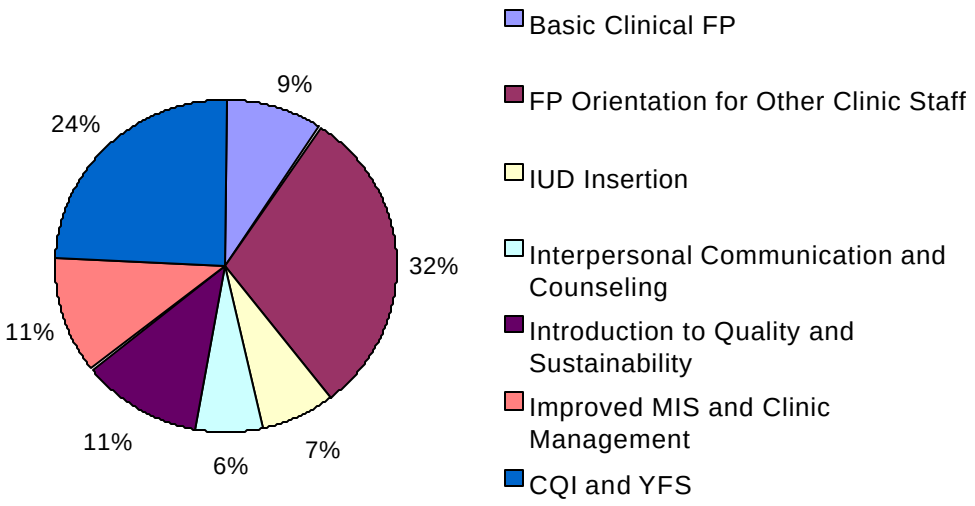


Chart 11. Lusaka Urban Training by Courses (N-219)



Training alone does not ensure appropriate follow-up or subsequent improvements in program or service quality. For this reason, SEATS designed a follow-up system to track the results (i.e., application) of training received by service providers. Building on SEATS' competency-based approach to training, the project sought to enhance the impact of training through follow-up visits to trainees, undertaken together with colleagues from the LDHMT. These visits took place between six weeks and six months after training with a view to assessing the providers' competence on the job and reinforcing newly learned skills.

SEATS adapted tools used by CARE/Zambia to guide the follow-up visits. They included checklists for observation of counseling, history-taking and examination of the client; a client exit interview and an assessment of the health facility – key instruments to assess quality of care. There were also forms to guide interviews to determine providers' and supervisors' qualifications and training, the extent to which they were using their skills and what sort of help they thought they needed. A key feature of the follow-up tools was the inclusion of client exit interviews which encouraged providers to focus on clients' perceptions and concerns about services, thus contributing to improving the quality of care.

By identifying what knowledge and skills were retained at various intervals post-training, and what skills were lost or still inadequate, revisions were made to training designs and curricula; and additional training and/or technical assistance was provided to help ensure the benefits and appropriate application of training received. At SEATS' wrap-up workshop, it was reported that 70 percent of trainees had retained their level of competency one year post-training, suggesting that the technical competence of service providers and hence, quality of services, has been improved as a result of training and education activities supported by SEATS. Under MAPS, for example, a pre-test showed 14.8 percent of midwives could list five characteristics of Youth-Friendly Health Services (out of a score of 100). A post-test

Improved supervision – improved quality:

At the beginning of the Lusaka Urban subproject, the project manager and a LDHMT representative carried out monthly supervision visits. During these visits, meetings were held with the clinics' in-charges to discuss problems, find solutions and share information. During one announced visit to a clinic, supervisors arrived to find the clinic locked while the only service provider had gone out to get supplies. A crowd of mothers was waiting outside for the provider to return. Some of the women had also come the previous day, but were not seen as the provider was busy. The women said this happens all the time. The project manager talked to the in-charge who said she knew nothing about this and promised to look into it. Other problems found during the supervisory visit included heavy workload and shortage of commodities. Often, service providers would rather take care of a crying baby first and let the FP client wait. This situation was discussed with in-charges at the monthly meeting and they promised to regard all services with equal importance. By the

showed 70 percent scoring 100, able to name five characteristics of YFHS.

Such follow-up exercises are strongly recommended to ensure the adequacy and appropriateness of human resource development efforts and their contribution to service quality.

C. Improved Institutional Capacities

From government institutions (i.e., DHMT, UTH, clinics) to private professional associations (i.e., ZNA) to PVOs (i.e., WV), SEATS has worked effectively to increase technical and management capabilities. Logistics systems and management have been improved through implementation of the "pull" system, leading to fewer stock outs and greater availability of a wider range of contraceptives and supplies. Institutional abilities to monitor and evaluate programs and activities have improved through theoretical training and direct experience with SEATS assistance (i.e., the PIR Package, mini-PLAs, FPPMES). New appreciation for, interest in and commitment to strategic planning and planning for sustainability have been brought about by rigorous efforts to include them as essential elements in program design and throughout the implementation and evaluation phases of activities (i.e., through the MAPS Strategic Planning/Business Management Workshop, regional sustainability workshops and subsequent development of sustainability plans for all activities). Data-driven decision making in program planning and resource allocation, as implemented in the Urban Initiative, has been enhanced through carefully crafted approaches to needs assessment, design and monitoring exercises. Ensuring broad participation and inclusion of all stake holders (i.e., service providers, community members, government officials) throughout the program cycle has both increased support for needed programs and improved the potential and mechanisms for sustainability.

Through all of the activities supported under SEATS, extensive collaboration with other CAs and other donors (as described in Section V – Implementation) has been paramount. USAID/Zambia is to be commended for both promoting and facilitating such an approach. SEATS' joint programming with ZFPS, CARE, MotherCare and the FOCUS Project, to name a few, has led to the efficient use of resources; reinforcement of consistent and successful technical approaches; broad-based support for capacity building; and improved potential for sustainability of important services and service quality. The collaboration experienced under specific project activities has expanded both the knowledge and ability of Zambian institutions to pursue ongoing support from a variety of resources – national and international alike.

VII. KEY LESSONS LEARNED

Referring to the detailed reports and documents listed in Appendix I, each subproject, Special Initiative and study has generated lessons, best practices and innovations that can help guide future RH planning and programming in Zambia. For this Final Country Report, however, only a few have been selected as examples of those SEATS believes most significant or noteworthy.

Access:

- Multiple approaches can be pursued to maximize access through underutilized resources. Comprehensive, multiple-intervention approaches can meet the needs of many audiences, including youth and other special segments of the population. The use of peer educators, providers trained in YFHS, creation of Youth Corners, community mobilization and upgrading professional association (ZNA) capacities all combined to expand access to services for youth in Zambia.
- Access to contraceptives and information is not enough in settings like Lusaka. Root causes of high-risk behavior may be more due to poverty and difficult social conditions than to lack of access to services. Providing access is only one essential step.

Quality:

- Expanding quality improvement and data-driven decision-making to the community level can successfully build support for youth services; encourage and facilitate youth utilization of services; and help health centers improve the quality of their services.

Sustainability:

- Programs that rely heavily on volunteers who have no other source of income have sustainability threats. Peer educators are an effective means of reaching youth with information and services, as reflected in project data and service statistics. Their sustainability, however, is uncertain due to the lack of structures and systems in place to assure ongoing support. Identifying a sustainable and appropriate package of compensation and incentives for peer educators is complicated and needs to be addressed from the earliest phases of program planning and implementation. Plans and resources to train new peer educators need to be available as original peer educators "age out" of the program.

Youth:

- Involving the community in a broad sense (i.e., parents, youth and community leaders) in program design, implementation (including training) and evaluation is highly accepted by the communities served and is an effective approach to promoting health and youth-friendly care.

- Youth liked the peer educator/Youth Corner approach to YFHS provision, and RH utilization increased as a result.

MAPS:

- Working through the provider professional association offers an established infrastructure to expand and reinforce interventions initiated under the project. Through the development of continuing education in YFHS, updates at branch meetings and a reactivated newsletter with YFHS messages and information, ZNA is in a position to help sustain project efforts to promote YFHS, increase access for youth and advocate on the part of providers attempting to improve services at their work places. In the process, CE helps strengthen the association by attracting new and reactivating dormant members.

Integration:

- Strengthening partnerships among NGOs, government and the community improves support for and sustainability of project activities. In WV, strong partnerships stimulated community support and willingness to contribute financially to sustain the program. Strong partnerships with government agencies created systems for sharing supervisory responsibility of community based services and sustainable supply distribution. The potential for sustaining and scaling up program interventions started by NGOs improves when linkages to government management, service facilities and supply systems are developed early and maintained.
- Linkages with integrated community development programs are needed to tackle problems that lead to negative RH outcomes but aren't addressed by FP/RH service providers (e.g., poverty, care for AIDS orphans, etc).

VIII. RECOMMENDATIONS

The lessons, innovations and best practices cited in the section above suggest directions and approaches that SEATS would recommend the GRZ and USAID/Zambia consider in future FP/RH planning and programming. Under the USAID ZIHP Results Package and in the National Health Plan, many of these approaches are already either embodied or indicated. Although the ZIHP covers the period from 1998 to 2002, many of its principles have been at the foundation of previous projects such as ZFPS, and have been operationalized through SEATS activities. SEATS believes that some of the lessons learned through its experience in Zambia merit immediate and careful consideration; and that they should be brought to bear on both current and future FP/RH activities undertaken in Zambia.

- USAID should continue its practice of promoting and facilitating collaboration and coordination among various CAs, donors, programs and in-country institutions. Such efforts help to increase efficiency, maximize resources and enhance the potential for sustainability. Strengthening partnerships at all levels will improve programs.
- Projects of relatively short duration should be followed up and re-assessed between six months and one year after their completion to determine the status of interventions and whether additional support is warranted and/or appropriate.
- Programs that rely heavily on volunteers who have no other source of income should include realistic and sustainable income generation activities in their design.
- GRZ and USAID should support efforts and programs that identify and develop underutilized and unconventional resources to increase access to FP/RH services and information.
- Successful models of trainee follow-up should be adopted and adapted in all programs that include training components as part of their implementation plan.
- Programs should promote and implement decision making (program planning, evaluation, modification) at the local level, using data-driven approaches and techniques. Every effort should be made to include the broadest array of stakeholders.

Again, Appendix I presents an extensive list of documents and reports that include additional lessons, recommendations and directions that might be considered and adopted for use in the Zambia family planning/reproductive health sector.

Appendix - I

I. RELEVANT DOCUMENTS

Zambia General

Actions for Moving the Zambia Health Reforms: FROM INVISIBLE TO VISIBLE. Ministry of Health and the Central Board of Health – Lusaka, Zambia. May, 1998.

Zambia Integrated Health Package (ZIHP): PHN Results Package. USAID/Zambia.

SEATS II Country Plan – Zambia. John Snow, Inc. USAID Contract #CCP-3048-C-00-4004-00. January, 1997.

Sexual and Reproductive Health Among Young Adults in Zambia: Selected Results of a Community-Based Study. Focus on Young Adults Program. USAID Contract #CCP-3073-A-00-6002-00. August, 1999.

Lusaka Urban District Health Management Team: Evaluation Report of the Youth Friendly Sexual and Reproductive Health Services Project in Lusaka Urban (March 1998 - April 1999) John Snow, Inc. September, 1999

Expanding Family Planning Services in Lusaka Urban District Subproject

Subproject Memorandum of Understanding (MOU): SEATS II – Expanding Family Planning Services in Lusaka Urban District. March 12, 1996.

SEATS II Midterm Evaluation Summary of Activities: Expanding Family Planning Services in Lusaka Urban District. February, 1998.

Report of the SEATS/DHMT End of Project Dissemination Meeting Held at Pamodzi Hotel, Lusaka, Zambia. April, 1999.

Subproject Quarterly Progress Reports: Technical/Narrative and Service Statistics by Shalote R. Chipamaunga and Anna Chirwa. October 1997 – September 1999.

Trainee Follow- up Tools – adapted by Shalote R. Chipamaunga.

Zambia Urban Youth Subproject

SEATS II Subproject Proposal- Zambia: Enhancing Reproductive Health Services in Lusaka Urban District Through Youth Activities. October, 1997.

FOCUS Trip Report – Lusaka. September 10-21, *1997.* Dr. Kate Bond. FOCUS on Young Adults Program. USAID Contract #CCP-3073-A-00-6002-00.

SEATS Young Adult Program, Zambia: A Report on the Mini Participatory Learning and Action (PLA) Exercise. Patrick M. Chibbamulilo and William Sambisa. January, 1998.

Subproject Quarterly Progress Reports: Technical/Narrative and Service Statistics. July 1996 – September, 1999.

Applying Best Practices to Youth Reproductive Health: Lessons Learned from SEEATS' Experience. March, 1999.

Zambia Nurses Association (ZNA)/Midwifery Association Partnerships for Sustainability (MAPS)

SEATS II Subproject Proposal – Midwifery Association Partnership for Sustainability (MAPS) Regional Initiative: Zambia. October, 1997.

Evaluating the impact of ZNA/MAPS Interventions on Reproductive Health Services to the Youths: Youth Friendly Services. Mrs. Lydia Jumbe. April, 1999.

Subproject Quarterly Progress Reports: Technical/Narrative and Service Statistics. October 1997 – September, 1999.

Reproductive Health Integration Initiative (RHII)/Performance Result 2 – Private Voluntary Organization (PVO) Site – World Vision

Integrating Reproductive Health into NGO Programs – Volume I: Family Planning. Joyce V. Lyons and Jenny A. Huddart. 1997.

Report: World Vision Zamtan Family Planning Project: Data Collection and Consultation. Joyce V. Lyons. September 21-24, 1998.

World Vision Zamtan Family Planning Project: Quarterly Review. Data Collection and Consultation. Joyce V. Lyons. April 14-16, 1998.

Zamtan Family Planning Project/Reproductive Health Integration Initiative: Lessons From the Field. Joyce V. Lyons. 1998.

Memorandum of Understanding: World Vision Zambia – SEATS. February 1999.

Appendix - II

ZAMBIA NURSES ASSOCIATION NEWSLETTER
A Quarterly Publication Highlighting ZNA Activities
March 1999

YOUTH FRIENDLY REPRODUCTIVE HEALTH SERVICES

THE major focus of the MAPS project has been to involve Nurses/ Midwives to offer quality friendly services to the youths.

From 25 February to 9 March 1999, two-day consultative meetings were held in Kabwe, Kitwe and Livingstone. These meetings which acted as refresher courses for ZNA/MAPS continuing educators trained in August of 1998, were also a fora for sharing information on Youth Friendly Health Services with other members of the Nurses Association and youth groups from different organisations working with health programms. Participants who were drawn from all the provinces were free to travel to a venue that was convenient to them among the above mentioned districts. Since the Ministry of Health ban on workshops was still in effect, participants attended in their own time.

These meetings aimed at sharing information on reproductive health problems facing youth and to strengthen the nurse midwives with information and communication skills to enable them conduct update sessions during branch meetings.

Among the people who attended the meeting in Kitwe was a Reverend from the United Church of Zambia whose contribution were very useful from the perspective of christian morals in Zambia. There was openness in sharing of information, experiences, views and ideas on youth and their reproductive, health and needs.

HIGHLIGHTS

Youths

The youth talked about their need for adequate knowledge about their reproductive development and health protection against STIs and pregnancy respect and privacy when they visit health centres.

☞ Page 3

ZNA membership is to be computerised

Did you know that ZNA Membership is being COMPUTERIZED?

All members are urged to submit completed new membership forms to their Provincial Representatives for onward submission to ZNA office for computerisation after which new ZNA membership numbers will be issued.

To those that haven't got the new membership forms, please liaise with your Provincial Reps.

The objectives for setting up the database include:

- **to monitor the growth of the organisation;**
- **to determine the number of members under ZNA;**
- **to help management run the organisation professionally;**
- **to provide management with data which would be used for decision-making purposes;**
- **to monitor the professional growth of its members;**
- **to improve the quality of services offered to members through easy accessibility to information;**
- **to improve the professional outlook of the organisation; and**
- **sustain the association through monitoring of payment of membership dues.**

☞ Page

ANNOUNCEMENT

ICN will be celebrating **100 years of Nursing caring** from 27 June to 1 July 1999 under the theme **Celebrating Nursing's Past... Claiming the Future**. See you there for those of you who will be going to attend the centennial.