MID-TERM ASSESSMENT OF THE ZAMBIA INTEGRATED HEALTH PROGRAM (ZIHP)

MARCH 5 - 23, 2001

PREPARED FOR USAID/ZAMBIA, LUSAKA

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ACKNOWLEDGMENTS

As discussed in the report which follows, the Zambia Integrated Health Program (ZIHP) is a complex undertaking directly involving the health-related components of the Government of the Republic of Zambia (GRZ) at national, provincial and district levels; many of the communities themselves within the twelve demonstration districts; the four cooperating agencies with the primary responsibility for ZIHP implementation; and USAID/Zambia. In addition, other cooperating partners (multilateral and bilateral donor organizations) as well as scores of private-sector organizations, non-governmental organizations, and community-based organizations are equally involved in collaboration in the implementation of ZIHP-related activities at all levels.

Therefore, in this summary acknowledgment the Assessment Team wishes to thank all of the organizations and individuals with whom we met and discussed their activities and accomplishments in relation to the ZIHP Program. Annex 5 contains a list of all the individuals interviewed during our ambitious three-week assessment. Their contributions were invaluable in helping us to fulfill our mandate of assessing the ZIHP Program, and we would have been lost without their strong support and involvement throughout the assessment.

LIST OF ACRONYMS

ADRA	Adventist Development and Relief Agency International
AIDS	Acquired Immuno-deficiency Syndrome
ANC	Antenatal Care
ARCH	Applied Research in Child Health
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
CA	Cooperating Agency, Cooperative Agreement
CBA	Community Based Agent
CBD	Community Based Distributor
CBO	Community Based Organization
CBOH	Central Board of Health
CCF	Christian Children's Fund
CHEP	Copperbelt Health Education Project
CHW	Community Health Worker
CMAZ	Churches Medical Association of Zambia
COP	Chief of Party
CSP	Country Strategic Plan
CSW	Commercial Sex Worker
CTO	Cognizant Technical Officer
DANIDA	Danish International Development Agency
DAPP	Development Assistance People to People
DFID	Department for International Development
DHMT	District Health Management Team
EBD	Employer Based Distributor
EPI	Expanded Program of Immunization
FHT	Family Health Trust
FP	Family Planning
FY	Fiscal Year
GNC	General Nursing Counsel
GRZ	Government of the Republic of Zambia
HC	Health Care
HEART	Helping Each Other Act Responsibly Together
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICASA	International Conference on AIDS and STDs in Africa
ICT	Integrated Competency-based Training
IEC	Information, Education, and Communication
IMCI	Integrated Management of Childhood Illnesses
IMI	Integrated Malaria Initiative
IR	Intermediate Result
IRH	Integrated Reproductive Health
ITN	Insecticide Treated Net
JHU	Johns Hopkins University
JICA	Japanese International Co-operative Assistance
JSI	John Snow, Inc.
MCH	Maternal and Child Health
MCZ	Medical Council of Zambia
MOH	Ministry of Health
MOST	Micronutrient Operational Strategies and Technologies

MOU	Memorandum of Understanding
MTCT	Maternal to Child Transmission
NIDS	National Immunization Days
NFNC	National Food and Nutrition Commission
NGO	Non-governmental Organization
NHC	Neighborhood Health Committee
NHSP	National Health Strategic Plan
NMCC	National Malaria Control Center
NORAD	Norwegian Assistance for Development
ORS	Oral Rehydration Solution
PAC	Post Abortion Care
PHMT	Provincial Health Management Team
PHO	Provincial Health Office
PHN	Population, Health and Nutrition
PIR	Performance Improvement Review
PLA	Participatory Learning Assessment
PLWA	Person living with AIDS
PPAZ	Planned Parenthood Association of Zambia
SCAN	Section 4.1.2.1 (page 40)
SCOPE	Section 4.1.4 (page 51)
SFH	Society for Family Health
SIDA	Swedish International Development Agency
SO	Strategic Objective
SPA	Sector Program Assistance
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
SWAp	Sector-Wide Approach
TA	Technical Assistance
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TDRC	Tropical Diseases Research Center
TSO	Technical Support Organization
UNAIDS	United Nations AIDS Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WFP	World Food Program
WHO	World Health Organization
YAO	Youth Alive Organization
YMG	Youth Media Group
ZIHP	Zambia Integrated Health Project
ZIHPCOMM	Communications and Community Partnerships
ZIHPSERV	Service Delivery and NGO Strengthening
ZIHPSOM	Social Marketing of Commodities and Services
ZIHPSYS	Policy, Planning and Systems Support
ZNA	Zambia Nurses Association

1. EXECUTIVE SUMMARY

Introduction and Background

This assessment of the Zambia Integrated Health Program (ZIHP) was conducted from March 5 – 23, 2001. The Assessment Team comprised seven members, of whom three are Zambian officials within the Ministry of Health, the Central Board of Health, and the Churches Medical Association of Zambia (on secondment).

Within a very ambitious three-week time frame, the assessment methodology comprised a team-building exercise, a combination of briefings by ZHIP and USAID, two concurrent field trips, a wide range of meetings and interviews with stakeholders, document review, data analysis and presentation, and feedback from both ZIHP and USAID. Following the team's work in Zambia, the Team Leader electronically coordinated feedback and report revision based on two further draft documents.

As stated in the Scope of Work for the ZIHP Mid-term Assessment (Annex 1), the overall purpose of this mid-term assessment is twofold:

- to review the first two years of ZIHP implementation and provide an assessment of performance, lessons learned, and areas for improvement; and

- to provide USAID with input into the design of future assistance to the Government of Zambia after the end of the current ZIHP Program.

Notwithstanding the complex nature of the ZIHP Program described in Section 4, the assessment has tried to analyze the overall program at the mid-point of its implementation time frame, providing an overview of the program by looking principally at two of its programmatic dimensions: the five intermediate results (IRs) to be achieved, and the four principal technical areas being implemented. Thus it provides the USAID Mission, its partners and stakeholders with an analysis of ZIHP's progress and constraints during its first two years, and recommends a number of ways in which ZIHP can improve its performance. In addition, the assessment suggests approaches for USAID's future program of assistance in the health sector.

In 1991 the Government of the Republic of Zambia (GRZ) embarked on a strategic program of health reform to achieve its ambitious vision of equitable access to cost-effective, quality health care as close to the family as possible. Within the overall context of health reform, the GRZ has reoriented highly centralized, vertical programs into decentralized, integrated programs. The major elements of the government's health reform program are:

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

Zambia's high rates of infant, child and maternal mortality, HIV infection and malaria prevalence are exacerbated by limited national resources to overcome these problems and achieve sustainable improvements in the health status of Zambians. The GRZ health reform program has the potential to achieve better health status, but requires focused attention to each of the major program elements.

The National Health Strategic Plan (2000-2005) was collaboratively developed by the GRZ and its stakeholders, and has become the focus for priority-setting and program implementation for the plan period.

During its current country strategic plan period, **USAID/Zambia's strategic objective for the health sector is "increased use of integrated child and reproductive health and HIV/AIDS interventions."** Five intermediate results (IRs) contribute to the achievement of this strategic objective:

- **IR 1:** Increased demand for PHN interventions among target groups.
- **IR 2:** Increased delivery of PHN interventions at the community level.
- **IR 3:** Increased delivery of PHN interventions by the private sector.
- **IR 4:** Improved health worker performance in the delivery of PHN interventions.
- **IR 5:** Improved policies, planning and support systems for PHN interventions.

This strategic objective and its intermediate results contribute directly and significantly to the National Health Strategic Plan (NHSP), and fit within its overall priorities. In turn, the ZIHP Program, while it directly represents only about half of USAID/Zambia's annual financial contribution to the health sector, contributes directly and significantly to all five IRs, and thus to the overall strategic objective. In doing so, it addresses essentially all of the health reform elements listed above In addition, each of the four ZIHP organizational entities contributes to more than one of the IRs through a complex, collaborative process which reinforces the effectiveness of each entity and the whole program.

The Zambia Integrated Health Program (ZIHP)

ZIHP's Vision Statement is perhaps the best way to summarize the ZIHP Program:

- The aim of the Zambia Integrated Health Program is to improve the health status of Zambians through partnerships with communities, government, NGOs and the private sector.
- The ZIHP partnership is based on the shared conviction that well-integrated and coordinated community-led interventions require an enabling environment as framed by the National Strategic Health Plan.
- ZIHP recognizes and supports the complex and dynamic nature of the Zambian Health Reforms.
- ZIHP seeks to support implementation of sustainable and low-cost interventions in four high-priority technical areas:
  - HIV/AIDS
  - Integrated reproductive health
  - Child health and nutrition
  - Malaria
- The Zambia Integrated Health Program provides a conceptual and organizational framework for ZIHP's program interventions, as agreed upon by both the GRZ and USAID.

The ZIHP Program was developed in 1998 to help achieve USAID's strategic objective. ZIHP was designed not as a vertical project but as an integrated program, and as an integral

part of the GRZ's sector-wide approach (SWAp) which forms the conceptual underpinning of the NHSP. USAID's experience since ZIHP began is that "only projects" or "only SWAp" doesn't work. There needs to be a combination of the two, so that the GRZ has untied funds for its operations as well as high-quality technical assistance to assist in achieving a supportive environment for health reform and achievement of the GRZ's objectives.

ZIHP is a consortium of four implementing partners, each of which has a major programmatic responsibility in achieving the program's objectives. Section 4 includes a summary of each of the four organizations.

- ZIHPCOMM – Communication and Community Partnership
- ZIHPSERV – Service Delivery and NGO Strengthening
- ZIHPSYS – Policy, Planning and Support Systems
- ZIHPSOM – Social Marketing

Assessment Outcomes

To achieve the first purpose of the assessment, the team was asked to review ZIHP's first two years of implementation by both intermediate result (IR) – the principal way in which USAID/Zambia measures its impact in achieving results – and by major technical area. Given the broad scope of the ZIHP Program and the many program interventions at different levels, presenting these two analyses comprises the majority of the report body. The second purpose – to provide guidance on the design of future USAID assistance to the GRZ – consumes considerably less space, but is equally important. Because of the interrelationships among the five IRs, the four program technical areas, the four implementing entities, and the many program interventions at different levels of the health system, the Assessment Team reached many conclusions and recommendations, which are summarized in Section 2. The remainder of this Executive Summary will highlight the major assessment outcomes, and finally will give an indication of how the remainder of the document is organized.

In summary, the Assessment Team wishes to compliment the GRZ, USAID and ZIHP on the significant progress that the ZIHP Program had made in its first two years of implementation. This progress has been across all dimensions of the program, and at all levels of government. The focus on district- and community-level programs is in tune with the Zambian health reform program, and has produced satisfying results in the areas in which ZIHP has provided support. Similarly, the program has taken important strides in increasing participation by the private sector, improving health worker performance, and improving health policy, planning and support systems.

Recurring themes. Except for the overview statement just made, the assessment results are so broad that they almost defy summarizing, beyond the summary conclusions and recommendations themselves. The results are perhaps best captured in several themes that recurred throughout the assessment process. These themes are based partly on perceptions and partly on reality, but they demand attention in order to optimize ZIHP's resources during the remainder of the program, and to have the greatest impact in achieving the National Health Strategic Plan.

- **Scope and breadth of ZIHP support.** In accordance with the design of the ZIHP Program, ZIHP's community-focused interventions have typically provided training and technical assistance for both community-level health workers and community agents of many types, especially the neighborhood health committees (NHCs). At the level of both the District Health Management Teams (DHMTs) and the NHCs, the problem that has arisen is that there aren't sufficient resources to fund the remaining costs of

implementing and supporting the service – transport, communication, drugs and equipment – and the newly trained health workers and community agents are unable to continue to provide the service or implement the program. Many of those interviewed have perceived this as a flaw in the ZIHP Program. However, ZIHP was designed as a collaborative program in which ZIHP would provide key inputs (training, technical assistance) and the DHMTs and communities, with support from the GRZ and other cooperating partners, would provide the logistical and other support. Unfortunately, the funding to the DHMTs from the central level, and from the DHMTs to the community level, has not been sufficient to provide the backup support. There are several major recommendations in Section 4 that reinforce this point. Initially, these recommendations stated that in order to overcome the problem and not delay implementation, ZIHP should provide the needed logistical and other support. However, the team has reassessed the situation in the light of the collaborative nature of the original ZIHP Program design, and now recommends that the GRZ, USAID and ZIHP (1) assess the reasons that these resources are not available through GRZ channels, (2) determine how to overcome the difficulty in each situation, and (3) regain the collaborative nature of the program that will lead to eventual sustainability. In order to emphasize the number of times the issue arose, the recommendation has been included each time but has been standardized to reflect the need to overcome the problem in a sustainable way.

- **Integration of ZIHP support with the programs of the DHMTs.** As discussed in Section 4, some GRZ officials perceive this as ZIHP having a "parallel structure" and implementing its own programs which are not fully linked with the corresponding DHMT programs. The team believes that this perception stems at least partly from the fact that ZIHP typically fully funds its training program but typically doesn't provide the cost information to the DHMTs. Similarly, owing to delays in its own availability of funds (and perhaps other reasons), when ZIHP initiates the activity the timing may not be right for the DHMT. Thus, ZIHP is seen as implementing its activities in a way that does not match the needs and resources of the DHMT.

- **Sufficient emphasis on sustainability.** The report contains a number of examples which question the sustainability of the intervention. Many of these are at either the district or community level, and many also deal with services based on newly obtained skills. Many of these examples are also accurate, since the way in which the intervention was introduced may not have taken the need for sustainability fully into account. However, two factors have been important in helping to ensure sustainability of many activities: (1) the policy, planning and system support component as a key element of ZIHP, and (2) ZIHP's emphasis on NGOs and the private sector.

Difficult choices. The Assessment Team suggests that the GRZ and USAID, together with ZIHP, consider all three of these themes, and perhaps others that emerge from the report's major conclusions and recommendations, and take action to overcome the underlying issues. As an expansion of the stated purpose of this mid-term assessment, the team suggests that this report should be used for four interrelated purposes:

- Reassessing ZIHP's current programmatic priorities and implementation strategies, and making adjustments where needed;
- Considering the need for a one-year extension of the ZIHP Program to consolidate any resulting realignment of priorities and resources, and to increase overall program impact in the remaining three years;
- Ensuring that key GRZ resources (e.g., provincial training teams) can be institutionalized, will be sustainable, and will continue to contribute to achieving the NHSP by the end of the ZIHP program; and
- Assessing the most appropriate concept and programmatic framework and content for USAID's program of assistance to the GRZ after the end of the current ZIHP Program.

In achieving these purposes the GRZ, USAID and ZIHP must make some difficult choices. First, there are now and will continue to be limits on the level of USAID resources available to the Zambia health sector. Thus, if the three partners reassess current program priorities and decide to implement some of the Assessment Team's recommendations for additional or expanded technical assistance and activities in the current program, other program elements will have to be curtailed or eliminated unless additional resources (e.g., those of other developing patners) can be mobilized. The same constraint will apply in determining the scope and priorities of the program of assistance after ZIHP. Second, the partners must focus on those program elements and activities that both will have the most impact in achieving mutally agreed results, and will ensure the desired level of sustainability at the end of the ZIHP program. Finally – and particularly in considering the three recurring themes above – the partners must carefully consider the "pace" of the ZIHP Program to ensure that it is not too ambitious in two ways: (1) that there is too much pressure to achieve program outcomes and results in an unrealistic time frame, and (2) that program outcomes are achieved in a way that ensures the desired impact and sustainability. In sum, the GRZ, ZIHP and USAID should learn from the lessons of the first two years of the ZIHP Program, and should both adjust the current program and design the follow-on program to capitalize on the ZIHP Program's most effective strategies and overcome its limitations.

Organization of the report

As noted, Section 2 comprises the summary of major conclusions and recommendations. Section 3 more fully discusses the purpose and objectives of the assessment. Section 4 looks at the first two years of ZIHP Program implementation, first organized under the five USAID internediate results, and then by the four key technical areas. Section 4 also addresses some specific areas requested by USAID, and a number of dimensions of ZIHP collaboration and management . Section 5 focuses on possible future directions for USAID/PHN assistance.

2. SUMMARY OF MAJOR CONCLUSIONS AND RECOMMENDATIONS

To help the reader quickly grasp an understanding of the significant outcomes of the assessment, the scope of work provided for this summary of conclusions and recommendations immediately following the Executive Summary. However, because of the large number of conclusions and recommendations (especially in the technical sections discussing the five intermediate results and the four technical areas), the team has divided the conclusions and recommendations into "major" and "supplementary." The major ones appear in this section, and the supplementary ones are in Annex 2.

In both summaries, the conclusions and recommendations are grouped under the title of their respective report sections. [To avoid confusion, the section numbers are shown in parentheses at the end of the titles, rather than at the beginning.] The conclusions are shown without headings, and each recommendation that relates to the conclusion(s) above it is identified separately.

IR1: Increased demand for PHN interventions among target populations (4.1.1.1)

ZIHP partners with CBOH in developing the various media campaigns and in supporting CBOH interventions. ZIHP also works with other government agencies and organizations, such as the NMCC, NFNC, and the General Nursing Council in developing materials. Collaboration has generally been good, though there have been problems with the NMCC and NFNC, who have at times felt side-tracked by ZIHP. Specific issues noted by these agencies were poor communication, the lack of sharing annual plans, and some problems in materials development with one agency. However, the CBOH was strongly positive about the quality of ZIHP's communication products, referring to the program as "a star."

ZIHP's integrated approach to increasing demand through a combination of social marketing, mass media, and community-level interventions has achieved a great deal in only two years. It has been successful in increasing national awareness of health issues and influencing attitude and behavior change, resulting in increased demand for health products nationally and for some health services in target areas.

ZIHP has used multiple channels and messages to influence community norms and reinforce health attitudes and behaviors, including the use of continuous and high quality mass media messages and campaigns. The mass media HEART campaign, for example, received a national award. ZIHPCOMM sees these interventions as both "household-level" and national-level strategies, since they reach the individual in his or her own home.

- **Recommendation:** ZIHP's collaboration with the CBOH in behavior change programs should be continued at the same level of investment during the remainder of the program.

Community mobilization training has successfully empowered NHCs to take a new proactive role in informing and organizing their communities around health issues. This role is reinforced through the distance education course for NHCs. However, there was a shortage of IEC materials at the health centers and NGOs visited.

- **Recommendation:** ZIHP should explore ways to continue to update and motivate peer educators and other community health workers, for example by using the NHC distance education model. ZIHP should also give priority to the plans to institutionalize and decentralize the distribution of materials in the public sector and consider supporting a central resource point for materials and information possibly based in a lead NGO. The

team also raised the issue of whether more print materials in local languages should be developed for literate but non-English speaking health workers. It is understood that ZIHP has assessed this question and takes the position that local-language materials would not be cost-effective.

The social marketing intervention has been highly effective in introducing new products, particularly ITNs and Clorin, as seen in the increased sales in districts visited. However, the team noted some stock-outs (ITNs in some sizes, Clorin bottles) at one ZIHPSOM district office and limited supplies held by some CBDs and EBDs of some products (condoms, contraceptives) particularly in rural areas. One problem identified was the difficulty small NGOs face in paying for social marketing products in advance.

- **Recommendation:** Communication with ZIHPSOM has clarified the fact that distribution of products at the clinic level is primarily the responsibility of the DHMT and that initial product provided on credit to the DHMT, NGOs, CBDs, and EBDs must be paid for before they can get more stock. ZIHP may want to discuss how best the different arms of ZIHP can collaborate in working with DHMTs to improve logistics, distribution, and financial planning to minimize such stock-outs. In addition, the TSOs, NGOs, and CBOs funded through the NGO grants program could benefit from training in how to assess needs and fund products. It will also be important to ensure that supplies in ZIHPSOM district offices are adequate to meet the rapidly increasing demand.

- **Recommendation:** The team appreciates the difficulty in reaching remote rural communities and urges ZIHP to continue to focus on these needy areas. ZIHP should consider the cost-effectiveness of investing in a second mobile video unit, to be based in the Kitwe/Ndola area, in addition to the unit based in Lusaka.

IR2: Increased delivery of PHN interventions at the community level (4.1.1.2)

ZIHP has been highly effective in the development and reviewing of demonstration district Action Plans and in the development of PLA activity plans at the community level. In both the Eastern and Central/Copperbelt Provinces, DHMT staff and leadership have appreciated ZIHP's input into the process. ZIHP inputs have come primarily in the form of training of community level personnel and the provision of technical assistance to the planning process.

ZIHP has been instrumental in improving the relationship between PHMTs/DHMTs and communities primarily through improved training of CHWs and NHCs, expanded planning with NHCs, more frequent supervision of CHW/NHC activities, IEC materials, social marketing, increased funding for selected NGOs, and increased operational support for Child Health Week.

The increased interaction between communities and health centers have increased the expectations of the communities with regard to the demand for and access to quality health services, service-related transport and basic referral services.

- **Recommendation:** To help ensure program impact, continuity and sustainability, overall program resource needs must be met. The GRZ, USAID and ZIHP should assess the reasons that needed backup support (drugs, basic equipment, transport, etc.) are not available, and should provide supplemental resources from among available options.

ZIHP has provided high-quality technical assistance to district and community level programs, particularly in the areas of training personnel (PLA, IMCI, IRH, policy, planning and social marketing). In districts with staff shortages, this technical assistance has been

especially appreciated. ZIHP assistance has been instrumental in the introduction and development of innovative systems for district/community planning, IEC material development, financing, social marketing and supervision.

Despite these key technical assistance inputs, the districts and communities are not fully aware of the process for accessing and developing peer review and learning resources from ZIHP. There is not "one-stop" shopping for the panoply of ZIHP activities. In addition, CBOH, PHMT, DHMT and NGOs/communities have no idea of the costs of developing/implementing such activities. This greatly limits the determination of the cost-effectiveness and replicability of such initiatives at the district/community level.

- **Recommendation:** ZIHP should work towards creating a greater awareness in the health sector of the array of ZIHP technical assistance capabilities and facilitation/realization of "one-stop" contacts for all ZIHP services from specific geographic areas.

In several meetings with more than 20 local NGOs in Eastern Province, it was observed that many established NGOs knew of the existence of ZIHP but did not have an appreciation of the multiple activities supported by ZIHP or the appropriate way to become more involved with ZIHP related initiatives/activities. In the words of one district level NGO, " WE don't really know what is happening with ZIHP". NGO leaders attributed this lack of knowledge to the absence of a full time representative in the district for all ZIHP components.

- **Recommendation:** In order to more rapidly reach high-risk populations, ZIHP must develop more frequent and effective communication and dialogue procedures to expand the involvement of local NGOs in ZIHP-supported areas of HIV/AIDS, child health, nutrition, IRH and malaria.

ZIHP has been instrumental in improving the supervision capacity of DHMTs for selected PHN interventions, particularly in the area of social marketing of ITNs/Clorin/contraceptives and Child Health Week.

ZIHP has been less effective in the provision of ongoing supportive supervision of health personnel with regards to continued improvements of the skills of the ZIHP trained personnel in IMCI and IRH. Numerous persons trained by ZIHP in these areas expressed the need for continued supportive supervision to meet the challenges of complicated IMCI and IRH conditions/cases in the community.

- **Recommendation:** ZIHP should modify the training approach for district- and community-level persons to include a more vigorous system of well-funded, quality, supportive supervision which insures a constant improvement of essential skills in community/district level personnel with regards to HIV/AIDS, child health and nutrition, IRH and malaria.

IR3: Increased delivery of PHN interventions by the private sector (4.1.1.3)

Targeting the private sector by ZIHP has been an effective way to increase access to PHN services.

- **Recommendation:** All private-sector programs undertaken by ZIHP have the potential or are already effectively increasing access to PHN services, and should therefore be continued or scaled up.

Private practitioners and traditional healers have been under-utilized as distributors for socially marketed products.

- **Recommendation:** ZIHP should consider innovative ways to increase utilization of private practitioners and traditional healers as outlets for socially marketed health products.

Policy issues and guidelines for interventions in the private sector are stagnating.

- **Recommendation:** ZIHP should continue to support the CBOH in the development of private sector policies and guidelines.

IR4: Improved health worker performance in the delivery of PHN interventions (4.1.1.4)

Overall, ZIHP has helped strengthen the technical and management capacity structures at the community, rural health centers and DHMT levels. This has been done through training and production of relevant technical materials, including guidelines and supervisory tools.

There is evidence to show that health worker performance has significantly been improved through the training facilitated by ZIHP. Notable training has been in the Integrated Management of Childhood Illnesses (IMCI), Integrated Reproductive Health (IRH), Integrated Competence based Training (ITC), Employer Based Agents (EBAs), Community Based Agents (Community Health workers, Neighborhood Health Committees), etc. Health workers in ZIHP demonstration districts perform better than those in non-ZIHP demonstration districts in terms of management of common illnesses; NHCs are able to produce quality Action Plans and Community Health Workers are able to do growth monitoring.

However, ZIHP support is mainly training and capacity building and not providing equipment (e.g., microscopes), supplies (e.g., drugs, needles, syringes), and logistics (e.g., radios, transport in form of motorcycles, bicycles or vehicles). This means health workers are trained adequately but lack the necessary equipment, transport, and drugs and supplies. For example, NHC members are trained and are able to come up with good Action Plans but lack the necessary funds to implement them, since the funding from the districts is highly inadequate.

Follow-up and supportive supervision of trained staff are inadequate. A number of cadres trained have not been followed up and are not supervised. A critical assumption underlying training is that the DHMTs will carry out supervision of trained health workers. ZIHP has helped build supervisory capacity by encouraging districts to nominate supervisors amongst the health workers for specific training programs. This ensures that these local supervisors follow up the health workers during routine supervision. ZIHP intends to assist the districts more through orientation of DHMT supervisors in supervisory skills, as well as to supplement funding to some DHMTs for supervisory activities. The current plan by ZIHP to strengthen the supervisory capacity of DHMTs should be commended.

- **Recommendation:** To have positive short-term and long-term impacts, the training needs should be well integrated with services. There is need to have a more comprehensive program that encompasses training, follow-up supervision and provision of equipment, supplies and logistics and support for an improved referral system through provisions of means of transport and communication systems. To help ensure program impact, continuity and sustainability, overall program resource needs must be met. The GRZ, USAID and ZIHP should assess the reasons that needed backup support (drugs,

basic equipment, transport, etc.) are not available, and should provide supplemental resources from among available options

ZIHP implementation of training activities is sometimes done at too short a notice. There are also questions about the cost-effectiveness of the practice where ZIHP staff comes from Lusaka and other distant places to train workers in Eastern Province, instead of using the trainers already present in the Province.

- **Recommendation:** ZIHP should consider decentralizing its training to the Provincial and/or District Offices, as this is expected to be more efficient, more effective, and more sustainable.

IR5: Improved policies, planning and support systems for PHN interventions (4.1.1.5)

Despite ZIHP's considerable policy development capacity building and technical assistance (primarily to the MOH), ZIHP's assistance to the CBOH has not yet met the need for policy skills and competencies in policy working groups. Unfortunately, the Policy Directorate in the CBOH is still vacant, adding to the need for additional ZIHP support. In addition, ZIHP's policy staff in the MOH has not been sufficient to meet the increasing need for rapid and rational health policy development

- **Recommendation:** ZIHP's policy assistance should be more comprehensive and should be supportive of the entire NHSP, and all levels of the system. The MOH/CBOH and ZIHP should reassess the highest-priority areas for policy assistance, and together refocus ZIHP assistance to meet these priorities. The ZIHP Health Policy Advisor (or perhaps two advisors) should assume a leading role in training and building capacity within the respective policy units. The Advisor(s) should also strengthen policy skills and competencies among the policy working groups. This in turn should streamline the development of policies, and may reduce the number of drafts – and the amount of time – required to achieve the final product. Acknowledging the current policy workload in both the MOH and the CBOH, ZIHP should consider providing another full-time policy advisor so that one can support each policy unit – both in providing technical assistance and in helping to build capacity.[1] In addition, the MOH and CBOH should fill their vacant policy unit positions as quickly as possible.

ZIHP can also provide assistance at the different policy implementation levels. For example, some policies developed at district level have originated from different organizations, and they typically don't correspond to those developed at the MOH/CBOH level. This means that they must obtain MOH/CBOH approval, which is a time-consuming and unnecessary step if the district-level policies had been derived from the corresponding central-level policy documents.

- **Recommendation:** National-level policies should be developed in such a way that there is a companion policy suitable for adoption and implementation at provincial and/or district levels, as appropriate.

ZIHP technical assistance has also strengthened several key aspects of the planning process. These include:

- Resource-based rather than need-based planning
- Decentralization of authority to districts for priority-setting in their own action plans

[1] Adding this full-time position will likely require a trade-off elsewhere in the ZIHPSYS or another ZIHP Program component.

- Simplification of the planning process, with a focus on USAID priority programs
- Articulation of the planning process at all levels.

However, the GRZ at all health levels receives no information on the financial resources used to achieve these excellent, positive results. Most ZIHP activities in various districts are directly funded by ZIHP, and as a result all the districts visited did not seem to know the total expenditure. As such, the districts have inadequate information for planning and budgeting similar activities, and cannot assess their potential sustainability once ZIHP has ended.

- **Recommendation:** Preferably, the flow of funds to ZIHP-supported activities within districts should flow through the DHMTs. Where this is not possible, ZIHP needs to quantify its resources for technical support. Thus far this information has not been provided to DHMTs even after the interventions and activities have been carried out.

Technical Area 1: HIV/AIDS (4.1.2.1)

Among other HIV/AIDS activities, the ZIHP program is providing a substantial contribution within the National Strategic Framework on AIDS to addressing behavior change issues for youth through its mass-media youth campaigns and youth-focused activities. However, there is a need to strengthen interventions to reach less educated and deprived youth.

- **Recommendation:** ZIHP's communication program should continue to support youth mass media campaigns aimed at urban and peri-urban youth, but should increase support for interventions to reach youth in rural areas, and out-of-school youth. ZIHP could explore using the NHC radio distance education model to create a supportive course for youth peer educators in collaboration with local radio stations.

ZIHP also promotes improved HIV/AIDS prevention and care in the community through training community peer educators and health staff to promote AIDS prevention and care in the community. However, ZIHP community-level support is mainly through the NGO grants program that supports NGOs working in HIV/AIDS.

There is a need to increase community involvement and empowerment to deal with HIV/AIDS. Despite the fact that communities defined HIV/AIDS as a priority area in 85% of their action plans, HIV/AIDS is not a major focus of the NHC community activities. Based on meetings with at least ten NHCs, the Assessment Team's perception of community priorities are that environmental health was a major concern, followed by issues of maternal and child health and malaria. With one exception, HIV/AIDS and STIs were not mentioned spontaneously by any NHC members or health providers interviewed, except those working in NGOs focusing on HIV/AIDS. Improved case management for STIs has not been a major focus of ZIHP training, and was also not perceived as being a priority at the local level.

- **Recommendation:** Future ZIHP workplans should ensure that all workshops and all training programs for CBAs will devote significant time to HIV/AIDS, and that NHCs will have the opportunity to consider options for HIV/AIDS activities in developing their action plans. ZIHP should also give priority to training providers in the syndromic management of STIs, and in training CHWs in promoting early recognition and treatment of STIs. These activities should be developed in collaboration with the national HIV/AIDS Technical Working Group on Sexually Transmitted Diseases.

The FACEAIDS program is a well-designed, introductory package to promote demand for HIV/AIDS services by companies. Experience from other countries shows, however, that workplace programs need some form of ongoing support. For example, the Bank of Zambia

representative stated: “when we need ZIHP, they are there.” Transition mechanisms need to be introduced to move ZIHP away from this implementation role.

- **Recommendation:** The Assessment Team understands that ZIHP recognizes the need to ensure the sustainability of FACEAIDS and has already identified an NGO to manage the program. We encourage ZIHP to identify additional Zambian NGOs as needed, with experience of workplace programs, who can provide this ongoing support.

Technical Area 2: Integrated Reproductive Health (4.1.2.2)

ZIHP has helped Zambian demonstration districts to make an impressive move towards integrating reproductive health activities.

- **Recommendation:** Continue to support the CBOH to finalize the policies, guidelines, and plan of action to move forward with the integration of services. Consider small operations research projects to document lessons learned and better practices related to integration of services.

Contraceptive uptake is low in some areas due to fears of side effects.

- **Recommendation:** Concentrate on dispelling myths about side effects of family planning methods through delivery of education messages/materials (ZIHPSOM and ZIHPCOMM) and through appropriate training of providers in counseling about side-effects.

Technical Area 3: Child Health and Nutrition (4.1.2.3)

ZIHP has played an important role in planning, developing and implementing Child Health Week in demonstration districts and provinces, particularly in the areas of:

- Planning orientation meetings for health center and related communities;
- Supporting key management, administrative and supervision activities;
- Providing key financial support for project implementation (KW120 million in 2000) to include materials, equipment, supplies and transport;
- Providing technical assistance related to the provision of child health services;
- Supporting supervision of provincial and district activities by the MOH and the National Food and Nutrition Commission; and
- Assisting with evaluating and determining the impact of national, provincial and district activities.

- **Recommendation:** ZIHP should continue to play a major role in the planning and supporting Child Health Week activities. National, provincial and district officials have indicated that in addition to continuing this role, ZIHP should consider expanding the Child Health Week mode of highly collaborative planning, operation and resource support to ongoing child health services within the demonstration districts throughout the remainder of the year.

ZIHP has provided excellent monitoring and evaluation formats for following the progress of CHWs and for providing health-related services for clients and target populations. However, the level of ZHIP resource investments in IMCI are not readily understood by CBOH, PHMT and DHMT officials. Without this understanding of overall resource investments, the GRZ

officials do not fully appreciate the cost-effectiveness, cost-efficiency, and sustainability of various IMCI program approaches and interventions.

- **Recommendation:** ZIHP should provide appropriate financial information related to various IMCI interventions, and should underscore the economic rationale for the IMCI model of care.

In almost all communities visited, there was a general lack of basic drugs, physical facilities, equipment, transportation and communications to deal with the multiple problems identified by the communities in child health and nutrition, and in the related areas of HIV/AIDS, IRH and malaria.

- **Recommendation:** ZIHP should continue to provide the package of PLA and NHC planning and implementation activities. To help ensure program impact, continuity and sustainability, overall program resource needs must be met. The GRZ, USAID and ZIHP should assess the reasons that needed backup support (drugs, basic equipment, transport, etc.) are not available, and should provide supplemental resources from among available options.

Social marketing efforts (especially for Clorin and ITNs) were highly visible and apparently effective interventions which were enthusiastically supported by NHCs. However, the enthusiasm for these "physical" interventions appeared to diminish community interest in other related diarrheal disease and malaria initiatives.

- **Recommendation:** ZIHP should continue to vigorously support the social marketing initiatives but should also develop similar high-impact strategies for other key diarrheal disease and malaria interventions through renewed IEC and supervisory emphasis.

Technical Area 4: Malaria (4.1.2.4)

ZIHP has contributed to and works within the National Malaria Strategy which includes early recognition, care seeking, ITN promotion, appropriate case management at health facilities, and prophylaxis for pregnant women.

The collaborative efforts of ZIHPSOM and ZIHPCOMM have helped government to raise awareness about malaria prevention, build demand for PowerNet, and market supplies of ITNs both nationally and in the four IMI districts. In these districts 30% of households now own ITNs. Recently, ZIHP has launched a new brand of ITN, Safenite.

While ZIHP has done very well in the Social marketing of ITNs and has created demand for them, re-treatment rates are as low as 10% -- possibly due to inadequate community sensitization, affordability, and at times inadequate supply of the chemical (e.g., in Kagunda NHC). ZIHP has made the promotion of ITN re-treatment its top priority, and hopes that net re-treatment rates will improve.

- **Recommendation:** Net re-treatment could be improved through use of "change agents" (influential community members), more effective promotion messages, consistent monitoring, ensuring a steady supply of re-treatment chemical, and perhaps even through entrepreneurial community members (or sales agents) who establish a local re-treatment service. However, ZIHP feels the current re-treatment messages are effective; the challenge is to reach the hard-to-reach and scale up the campaign. ZIHP should do exactly that: continue to use the current messages on a larger scale and develop strategies for the messages to reach the remotest parts. Since the responsibility for distribution of ITNs is now going to shift to the DHMTs, the team recommends that ZIHP

continue to offer necessary logistical and technical support to the DHMTs until it is satisfied that the DHMTs can cope with this responsibility.

Currently, ZIHP is not active in the promotion of other malaria control strategies like house spraying and environmental control. The malaria prevention messages are not comprehensive enough, but tend to focus on ITN promotion. ZIHP strongly feels they have no reason to include other messages because ITNs are the *best* prevention method available to and affordable by households in Zambia.

- **Recommendation:** The assessment team agrees with ZIHP's strategy to promote ITNs as the best prevention measure. However, the team does not think that the Zambian people should be given the picture that *no other* method of malaria prevention works and is affordable because that is not true. No single method will control malaria. ITNs only work when someone sleeps under them; we should note that there are a number of people exposed to infected female anopheline mosquito bites before they actually go to sleep. Hence messages on personal protection and messages that teach people about the biting habit of the gambiae complex anopheline mosquito are important. Targeted vector control is also effective for those who can afford it. We therefore recommend that ZIHP malaria IEC messages should continue to promote ITNs as the best malaria control method but should not discourage other complementary measures of malaria control. Other IEC messages should emphasize the benefits of using other methods as well.

ZIHP Contribution to GRZ Health Reform (4.1.3)

ZIHP has provided substantial support to the health reform process in systems development, capacity building, policy development, planning and budgeting, etc. Most of the people interviewed indicated that ZIHP, through USAID, is a major partner in realizing the objectives of the health reform vision. It was evident in the field that partnerships with the community to take care of their own health problems have been enhanced in program sites. In addition, private-sector participation in the provision of health services through social marketing and employer-based agents has begun to take shape. All these are major elements of the reform process.

Despite these positive contributions to health reform by ZIHP, during the Assessment Team's interviews and field visits a number of people representing GRZ institutions at central, provincial and district level perceived a structural problem between CBOH and ZIHP, which they feel has led to competition rather than complementarity. Even if activities appear to be integrated into one action plan, implementation is sometimes done in a parallel fashion. As just noted, the framework for providing support to the health sector is through the National Health Strategic Plan (NHSP), and support can be through a "financial basket" and/or an "activities basket." ZIHP's support contributes to the basket of activities, which have been prioritized within the NHSP at various levels of the health care system. The ZIHP Program comprises approximately half of USAID's annual financial contribution to the health sector. On the other hand, about 10% of USAID's annual contribution is from its Sector Program Assistance (SPA), and these funds flow directly into the financial basket.

Some of the same GRZ officials in the field also raised the issue of efficiency in implementation of activities. There was a feeling that if activities in ZIHP's four technical areas were well coordinated and implemented with CBOH activities at provincial and district levels, there are likely to be gains in both efficiency and effectiveness resulting from the synergistic effect. Decentralizing some ZIHP activities to provincial and possibly district levels was also widely mentioned. However, since provincial offices have only recently been established and staffed, their absorptive capacity may be limited initially. Provincial Offices and DHMTs indicated that sustainability could only be achieved by developing capacity at

these levels and then decentralizing some of the activities currently being initiated centrally. Transparency was also identified as a concern, in the sense that ZHIP has not been providing information on the cost of its field programs. This has implications on future planning and sustainability at provincial and district levels, since the financial implications of program expansion are not clear.

- **Recommendation:** During the remaining implementation period of the ZIHP Program, ZIHP and the CBOH should emphasize achieving more complete integration in planning, budgeting and implementing activities, so that ZIHP more effectively complements the achievement of the strategic plan objectives. Integration is important for gains in both efficiency and effectiveness, and it can also strengthen partnership between CBOH and ZIHP.

Importance of Behavior Change (4.1.4)

Behavioral change interventions have been of very high quality, well designed based on research findings and a clear conceptual framework, and effective. Research has shown that viewing and listening to mass media and social marketing interventions correlates with behavior change in terms of condom use. ZIHP should be commended for its focus on continuing research that feeds back into program design.

ZIHP's support for youth organizations has also been very effective in institutionalizing input from youth into youth programs, and in extending the number and reach of materials aimed at youth. However, organizations outside Lusaka are not aware of programs and materials developed by the Lusaka youth organizations, and are not in contact with them.

- **Recommendation:** Networking mechanisms and co-training arrangements to link youth organizations should be supported through YAO, and the distribution system for materials should be expanded to include provincial- and district-level youth-focused NGOs.

Coordination of behavioral change activities between ZIHPCOMM and ZIHPSOM is good, and the two agencies have overcome initial tensions. Coordination to integrate behavior change approaches into district-level interventions still needs to be strengthened.

- **Recommendation:** Systems are not yet in place to build the capacity of DHMTs and NGOs to analyze the behavior change environment and to develop long-term communication strategies at the district level. The peer educator and social marketing approach needs to be balanced by behavior change interventions based on a deeper analysis of how to influence community norms. There should be a greater focus on IEC capacity building. ZIHPCOMM plans to work with DHMTs and communities to develop plans based on the SCOPE planning tool. ZIHPCOMM should give priority to this program, and should ensure that there are adequate follow-up and supplementary training in communication approaches, as defined by the district situation analysis.

Technical Asistance to Designated Partners (4.1.5)

ZIHP has provided significant initial technical assistance to its major NGO partners in building their managerial and technical capacity in a range of areas. Training in the PIR was particularly effective and appreciated. There are already examples of the multiplier effect of this training.

- **Recommendation:** Document the multiplier effect of ZIHP technical assistance as far as possible, for instance through requesting information from TSOs and lead NGOs on their use of ZIHP skills and approaches in other contexts.

ZIHP's focus on achieving results conflicts with the need to move at a pace that recognizes the coordinating role of its partners, and also fits with their schedules and human resource capabilities. Short-term notice of technical assistance activities has also created some tensions. These concerns about partnership were expressed at both the DHMT and coordinating NGO level.

- **Recommendation:** ZIHP should review the joint planning process for NGO activities with DHMTs and TSOs, and improve on communication issues. USAID should also review its measures for assessing ZIHP performance to include assessments of ongoing partnerships. While this may reduce quantitative results, it will likely increase sustainability, which is probably a more important indicator.

Overall Coordination of ZIHP and ZIHP+ Program (4.2.1.1)

Discussions with the ZIHP COPs and others make it clear that coordination among the four ZIHP cooperating agencies in managing the overall program was obviously initially a major challenge. It took essentially the first year for the four entities to work out a mutually acceptable form of internal management that encouraged synergy among the four, but also provided the required measure of individual organizational autonomy. This is partly because only one entity had a stipulation in its contract to ensure coordination among the four. Also, the four have equal status, with none as the principal agency or prime contractor.

After two years of working together, the four entities have made the necessary adjustments and have mutually achieved a workable level of collaborative management and program implementation. As indicated throughout this report, there are many examples of the positive impact of this collaboration in what ZIHP has achieved. However, there are still acknowledged tensions among the four entities, and the ongoing collaboration requires considerable time and energy to maintain.

While the collaborative environment that has evolved is now working well, it is not because of formalized managerial linkages among the four entities. In fact, based on the COP interviews, the four CAs clearly prefer ZIHP's informal consortium mechanism to a formal prime contractor/subcontractor arrangement. This is partly because each would want to be the prime contractor, and partly because components that are subcontracted can be limited in scope and prominence by the prime contractor – often to the detriment of overall program balance and impact. The Assessment Team identified three important factors that have made the successful collaboration work: (1) guidance and direction from the USAID Mission, (2) the unique combination of individual personalities and skills among the COPs, and (3) the sheer organizational will among the four CAs to make it work.

If USAID/Zambia is confident that these factors will continue to exist in another ZIHP-type program after the current program ends, then the advantages of the ZIHP-type collaborative arrangement will continue to exist, and future program objectives should be met. Otherwise, a more formalized management structure will be necessary to ensure the successful management of the technical assistance program that will follow the conclusion of ZIHP. This kind of arrangement would also streamline the management of the program by USAID/PHN. The risk of not increasing the degree of formalization of the overall management structure is that the critical collaboration will not be sufficient, and the program's results will not be fully achieved. If this option were chosen and this situation

arose, then USAID would probably want to amend the contractual arrangements of each CA in order to formalize the management structure.

- **Recommendation:** Should the GRZ and USAID/Zambia decide to continue a ZIHP-type program after the current program ends, USAID will need to be careful in the planning and procurement of technical assistance to ensure that the needed collaborative linkages exist in the new program. Otherwise, some contractual amendments may be necessary to ensure an overall management structure that will produce the collaboration required to achieve the program results.

The second dimension of overall coordination involves the linkages between the ZIHP Program and a large number of field-support-funded cooperating agencies that are working in Zambia, which collectively have come to be known as "ZIHP+".[2] Some of these cooperating agencies were operating in-country prior to the implementation of ZIHP. Each ZIHP+ organization focuses on a specific, specialized area of technical assistance that supports USAID/Zambia's overall program of assistance. The range includes specialized technical areas (e.g., micronutrients), management (e.g., health logistics management), and operations research (e.g., quality assurance). Further details concerning the relationship between ZIHP and the ZIHP+ entities are included in Section 4.2.2.4 below.

Some of the ZIHP+ agencies are more closely linked to the ZIHP Program than others, and several operate essentially on a national scale. The fact that their relationships with ZIHP are so varied complicates the way in which collaboration works among them. Although the scopes of work of the ZIHP+ entities typically extend beyond that of the ZIHP Program, many are now working at the district level as well.

While some of the ZIHP+ CAs are providing highly specialized technical assistance and focusing on operations research, others are providing planning and management TA that could be incorporated into the scope of work of one or more of the new ZIHP-type entities. For example, among the current ZIHP+ CAs, the logical scope of work that might have been incorporated into ZIHPSYS would be that of RPM+. Similarly, the HIV/AIDS policy work being done by the Policy Project could also have been incorporated into ZIHPSYS. The advantage of including program elements like this into a ZIHP entity is that they can be more carefully focused on the specific needs of the ZIHP Program in supporting the sector-wide approach. In addition, reducing the number of ZIHP+ CAs would decrease the number of management units in the USAID/PHN Office, and thus reduce the management burden.

- **Recommendation:** Should the GRZ and USAID/Zambia decide to continue a ZIHP-type program after the current program ends, USAID should consider integrating selected high-priority skills necessary to support the major ZIHP-type implementation components into the contractual scopes of work of the ZIHP-type contractors. However, field-support-funded CAs may still be the best mechanism for obtaining other, more specialized skills required for programs that extend beyond those of the ZIHP-type program.

Individual Management of the Four ZIHP Prime Contractors (4.2.1.2)

[2] There are eleven cooperating agencies with in-country staff that USAID/Zambia includes in the ZIHP+ group: Applied Research in Child Health (ARCH), JHPIEGO/MNH, JHPEIGO/TRH, IMPACT, Micronutrient Operational Strategies and Technologies (MOST), Rational Pharmaceutical Management Plus (RPM+), Linkages, the Policy Project, Health Policy and Systems Strengthening, JHU/PCS, and the International AIDS Alliance. In addition, four other field support CAs support the Zambia program but do not have an in-country presence: the Quality Assurance Project, DELIVER, HORIZONS, and Synergy.

The ZIHP model relies on strong collaboration among the four CAs in order to function effectively. However, the management structure and function of each ZIHP entity can also have an effect on the others.

Based on group discussions with the four COPs and their deputies, and with the four USAID/PHN cognizant technical officers (CTOs), the Assessment Team concluded that the management of the four entities varies considerably. This is to be expected among four different contractors, and is not a problem with truly internal management.

USAID and ZIHP have developed a number of mechanisms to help ensure full coordination across the four ZIHP components. These include: (1) a single ZIHP workplan that integrates all four CA activities and results to be achieved; (2) biweekly meetings among the ZIHP COPs where joint issues are discussed; (3) joint technical working groups; and (4) weekly USAID/PHN staff meetings where the four ZIHP CTOs report on individual meetings with their ZIHP counterparts.

Nonetheless, there is sometimes a tendency for each ZIHP entity to focus on achieving its own workplan agenda, and each does not always adequately take into account the activities of the other three – and the linkages and interrelationships among them -- in achieving the overall ZIHP workplan objectives. This situation is complicated by the fact that the five IRs represent the primary dimension by which achievement is measured, and most of these require major contributions by several contractors.

- **Recommendation:** In workplan planning, execution and monitoring, ZIHP and USAID/PHN should ensure that each ZIHP entity is managed in such a way that each is fully involved and working collaboratively to create the synergistic effect necessary to achieve the indicated results.

Relationship Between ZIHP and Government Partners (4.2.2.1)

ZIHP is currently providing technical support to the Ministry of Health and Central Board of Health nationally and in 12 demonstration districts. This includes working with MOH/CBOH and District Health Management Teams (DHMTs) on policy and systems development, planning and budgeting, capacity building, quality assurance etc. Other districts also benefit from ZIHP activities because of spin-off effects in key areas, and ZIHP is now including neighboring districts in several implementation activities. As noted above, ZIHP also provides technical assistance to the central level in planning and policy development, as well as in the four technical areas. ZIHP also collaborates with the GRZ through the CBOH technical working groups, the Basket Steering Committee, etc. Further, ZIHP collaborates with the Medical Council of Zambia (MCZ), the General Nursing Council (GNC), Chainama College for Health Sciences, and various nursing colleges in curriculum development for pre and in-services training. ZIHP also collaborates with the Tropical Disease Research Center (TDRC) and National Food and Nutrition Commission (NFNC) on Vitamin A.

In HIV/AIDS prevention, ZIHP collaborates with the HIV/AIDS Council and Secretariat. In addition, there is also collaboration with the Ministry of Education especially primary and secondary schools in the same technical area. Schools have formed Anti-AIDS clubs which have been instrumental in the preventing this disease. ZIHP has also trained employer based agents from both public and private sectors. These agents are providing services in the four technical areas to their fellow employees.

- **Recommendation:** Even though there is good collaboration between ZIHP and the GRZ partners in many areas, ZIHP and the CBOH need to integrate and coordinate activities better. This will provide efficiency gains, foster a stronger partnership, and

ensure sustainability of the activities ZIHP is currently supporting. Thus, during the remaining two years of ZIHP, CBOH and ZIHP should work on improving this coordination and integration, and in planning and implementing activities together.

Relationship Between ZIHP and NGOs and the Private Sector (4.2.2.2)

One of ZIHP's key roles has been to help government by expanding the involvement of the private sector and NGOs in financing and delivering health services. ZIHP is helping the GRZ to increase the number of workplaces receiving HIV/AIDS services, as well as to increase the number of private-sector service delivery channels providing PHN interventions. In this way, ZIHP contributes to the Health Reform vision by increasing access to health services.

- **Recommendation:** ZIHP should continue to strengthen partnerships that will expand and improve the delivery of community-based health service by involving communities, CBOs, NGOs, traditional healers and the DHMTs. ZIHP should also continue to provide needed technical assistance to CBOs, NGOs, and Church Organizations/Churches, including CMAZ.

Relationship Between ZIHP and Cooperating Partners (4.2.2.3)

Over the past decade, the GRZ's cooperating partners have played a major role in supporting the Zambian health sector. Cooperating partners currently contribute approximately 45% of the GRZ budget for health services. At present, some 30% of all hospital beds are operated through private-sector (primarily church-related) institutions.

ZIHP is currently collaborating with many cooperating partners in implementing effective joint activities. Strong and effective collaborative efforts have been developed and are contributing to improved and expanded services in the areas of malaria, HIV/AIDS, IRH, and child health and nutrition.

- **Recommendation:** As opportunities arise, ZIHP should expand its collaborative linkages with key cooperating partners. As with other assessment recommendations, ZIHP should document the effectiveness of and lessons learned from these collaborative efforts, including clear estimates of programmatic and/or health impacts and program costs.

For the reasons cited in the key findings, the trend among the GRZ's cooperating partners is to commit a greater percentage of development resources towards SWAp and basket-funding approaches. However, the programs of all of the cooperating partners who met with the team also include projectized and/or long-term expatriate technical assistance components.

Another important factor is that since 1999, via its Sector Program Assistance mechanism, USAID has budgeted approximately $2 million per year, or 10% of its total annual health program funding, directly to the district basket. A total of $2 million has been disbursed to date under this arrangement.

Unfortunately for the ZIHP Program, the district-basket-funding mechanism is used to fund the regular activities of the DHMTs nationwide, including a small percentage the DHMTs pass on for community-based activities. Based on information from the Assessment Team's field trips, the problem is that the basket-fund allocations from the CBOH represent only a fraction of the DHMTs' budgets, and the DHMTs must make difficult choices in allocating

these funds among their priority needs. Typically these funds go towards salaries and other critical needs, and there are insufficient funds for program support, especially at the community level.

- **Recommendation:** The joint GRZ-USAID design of the ZIHP Program specifically envisioned a cost-sharing approach by the GRZ to provide those programmatic resources (drugs, transport, etc.) that complement ZIHP's planned inputs. Since the absence of these programmatic resources is clearly a critical problem affecting ZIHP Program implementation, the MOH/CBOH and USAID should determine the reason(s) that they aren't available from the GRZ as anticipated, and rectify the situation.

- **Recommendation:** Because of the relative importance of SWAp and basket-funding approaches, ZIHP should offer to collaborate in the planning and evaluation of these programs at district, provincial and national levels. In addition, ZHIP should assist the GRZ, where feasible, to document the effectiveness of these efforts in terms of both short- and long-term improvements in the health system, and the resultant health impact.

Relationship Between ZIHP and Field-Support-Funded Organizations (4.2.2.4)

The various connections between the ZIHP+ activities and ZIHP are too complex to capture or describe easily, but all are in some way collaborating with, joint funding with, or otherwise coordinating with ZIHP. This kind of coordination is rarely seen with USAID-funded programs in other countries, and is very beneficial in terms of avoiding duplication, capitalizing on complementary skills and interests, and having maximum impact on the population served. In summary, the field support projects are filling a technical assistance niche and coordinating well with the ZIHP Program.

- **Recommendation:** With the proviso noted in Section 4.2.1.1, USAID should continue to use field support projects as needed to provide priority, specialized technical assistance to complement the overall USAID/Zambia PHN program.

Relationship Between ZIHP and USAID/Zambia (4.2.3)

Based on interviews with both the ZIHP COPs and their deputies and the USAID/PHN Cognizant Technical Officers (CTOs), the working relationship between ZIHP and USAID/Zambia is generally both cordial and effective. However, the USAID/PHN managers have both technical and management responsibilities. Heavy workloads in both areas sometimes conflict with one another and sometimes affect the ZIHP relationship and ZIHP program management. Each of four USAID/PHN managers has CTO responsibility for one of the ZIHP Program entities (e.g., ZIHPCOMM), but as reported by the ZIHP COPs and deputies, typically the technical responsibilities of the CTOs don't correspond well with their ZIHP management responsibilities. As viewed by ZIHP, despite significant improvements within the last year, the overall result is that the working and managerial relationships for the four ZIHP entities are not uniformly strong and effective.

- **Recommendation:** Notwithstanding the need for technical responsibilities among the USAID/PHN professional staff and competing priorities among the staff's overall roles, USAID/PHN and ZIHP should jointly develop ways in which the four USAID CTOs can be more effective in managing their respective ZIHP entities. This should include creative ways to improve coordination both among themselves and with their ZIHP counterparts, in order to optimize the interrelationships among the four ZIHP components. Ensuring that the biweekly COP/Deputy and CTO meetings are held would also help. Modifying

overall work responsibilities of individual CTOs may be needed in order to make the workloads more manageable.

Data Management Systems (4.2.4)

ZIHP and its collaborating organizations have designed and implemented systems for managing and monitoring ZIHP Program activities at all levels. This includes DHMTs, NGOs, CBOs, community health facilities and NHCs. Although the team found that it was usually impossible to obtain data in the field (other than "charts on the wall") from most of these entities on short notice (since the person responsible wasn't available), one exception was the information available from ZIHPSOM. First, ZIHPSOM field representatives usually had key statistics and information in their heads -- sales figures and trends, quantities of each product sold and in stock, etc. In addition, when visiting the ZIHPSOM district offices in the Copperbelt, this information was readily available and appeared to be valid.

- **Recommendation:** ZIHP should work with its partners in the field to ensure that the value of management information is understood, and the information is readily available for planning and evaluation purposes.

Option of a One-year Extension of ZIHP (5.1)

As described in Section 4, the Assessment Team has concluded that the ZIHP Program is making many significant contributions to the Zambian health sector in achieving the NHSP, especially in the areas of capacity-building and increasing community-level involvement in their own health. However, there are both positive and negative factors that must be weighed carefully in assessing whether ZIHP should be extended beyond the current four-year time frame.

- **Recommendation:** Given this complex range of considerations (summarized in Section 5,1), and within the short timeframe of this assessment, the Assessment Team could not reach a consensus and thus cannot make a recommendation either to extend or not extend the ZIHP program for a fifth year. The team therefore recommends that the GRZ and USAID begin now to consider the above factors and others that may influence the decision of whether to extend ZIHP or not, and reach a fully reasoned decision in the near future.

- **Recommendation:** Whether or not the GRZ and USAID decide to extend the ZIHP Program for a fifth year, this mid-term assessment has provided many good ideas on how the current ZIHP Program might be modified and focused during the remaining two or three years. A fifth year would allow these programmatic shifts to achieve more impact and perhaps prepare the way for the new program of assistance, but even without a one-year extension the changes would make a difference in overall ZIHP achievements and tangible benefits to the GRZ. Among the recommendations made in Section 4, many fall into the following categories:

- Based on mutual agreement, focus on a limited number of interventions that represent the highest-priority areas of support.
- Plan, budget for, and coordinate ZIHP program resources together with the GRZ and/or cooperating partner resources that are required ("backup support") to implement these priority programs effectively at central, provincial, district and community levels.
- In particular, focus on capacity building (especially training capacity) at the provincial and/or district levels, so that there is a reasonable level of sustainability at these levels by the time the current ZIHP Program ends.

- Increase the number of ZIHP technical experts working with MOH/CBOH counterparts on a long-term basis. Success thus far in the policy area has been impressive and the assistance has made a difference.

- **Recommendation:** The team also recommends that the GRZ and USAID/Zambia urgently undertake the conceptualization, planning and design of USAID's future program of assistance to the GRZ, so that there will be a smooth transition from ZIHP to the new program.

Program Assistance After ZIHP (5.2)

During discussions on the nature of future program assistance with both GRZ and USAID officials and others, the Assessment Team heard a wide variety of opinions and suggestions. The key underlying issue that appears to influence people's responses is their perception of the extent to which -- and how effectively -- the current ZIHP Program meets the objectives of the NHSP; in other words, ZIHP's contribution to GRZ health reform. Another key factor is the question of technical assistance in relation to the alternative SWAp and basket-funding approaches. A third, interrelated point relates to ZIHP's contribution to the long-term sustainability of the GRZ health care system.

One important consideration affecting these factors is the general framework through which USAID provides development assistance. As a result of US Congressional requirements and USAID assistance parameters, most USAID development assistance to most countries is in the form of programmatic support rather than basket funding. For a variety of reasons, it is not likely that this situation will change in the foreseeable future, although USAID's contribution to basket funding in Zambia is an example of USAID's flexibility in meeting national program priorities. Therefore, GRZ and USAID negotiations on future assistance should make effective use of USAID's technical assistance capabilities by combining them effectively with both GRZ resources and those of other cooperating partners and other agencies.

USAID technical assistance programs tend to (and should) provide world-class technical and management experts who can assist developing country counterparts to develop creative solutions and systems that will overcome health system problems and limitations. In other words, USAID's program focus can and does support the sector-wide approach (e.g., policy and planning assistance, health logistics systems development, private-sector involvement). As discussed in Section 4.2.3.3, the fact that many of the GRZ's cooperating partners have linked their programs with ZIHP would seem to underscore the importance of high-quality ("project") technical assistance when effectively combined with other approaches and resources. Clearly, these synergistic kinds of partnerships should continue to be pursued in developing the next program of assistance.

During the discussions, there seemed to be a lack of recognition by some officials of the collaborative nature of the original ZIHP design, and what the design required in terms of providing resources, and by whom. As noted in the Executive Summary and reflected in many of the Assessment's recommendations, many GRZ officials at central, provincial and district levels were concerned that the ZIHP Program didn't provide all the necessary backup support (drugs and supplies, transport, etc.) that were required to complete ZIHP field activities. This was often characterized as providing the training for health and community workers to learn new skills, but not the "tools" they needed to practice those skills. However, the joint GRZ/USAID ZIHP Program design clearly indicated that ZIHP would be responsible for certain inputs (typically training and technical assistance) and the MOH/CBOH would be responsible for others (typically the needed "tools"). In other words, the intended mix of resource contributions hasn't consistently worked well, in most cases because the DHMT (or

other GRZ entity) did not have the budgetary resources to provide the backup support when needed. As noted in other sections of the report, there were also a number of occasions when ZIHP activities were delayed, and the required GRZ resources weren't available on short notice to meet the revised implementation schedules. In designing the next program of assistance, the GRZ and USAID must carefully analyze the reasons for the difficulties that have hampered the current ZIHP Program implementation, and must identify workable solutions for these problems and incorporate them in the new design.

- **Recommendation:** Given the nature of USAID's worldwide program assistance mechanisms, USAID/Zambia's new health program should be built around a core of high-quality technical assistance, linked to other resources that together can have a major impact in helping the GRZ to achieve its NHSP. The ZIHP Program has demonstrated the value -- both operationally and programmatically -- of the integrated program approach, and implementation has generally been very effective. The GRZ and USAID should learn from the lessons of the first two years of the ZIHP Program and should design a future program that capitalizes on ZIHP's most effective strategies and overcomes its limitations.

As discussed in Section 4.2.1.1, the collaboration among the four ZIHP CAs is working well because of the existence of three key factors: USAID guidance and direction, the unique combination of COP personalities, and the organizational will among the four entities to make it work. If USAID/Zambia is confident that these factors will be present in a follow-on ZIHP-type program, then the advantages of the ZIHP-type collaborative arrangement will help ensure that future program objectives will be met. Otherwise, a more formalized management structure will be necessary to ensure the successful management of the technical assistance program that will follow the conclusion of ZIHP.

- **Recommendation:** The team feels that the continuation of a comprehensive, integrated health program makes sense in the Zambian context. Based on the inputs the team received during many interviews and meetings during the review, USAID should consider using a ZIHP-like organizational structure to implement the future program of assistance with the GRZ. If the same kind of creative and resourceful implementation arrangement exists, it will go a long way in helping to achieve the results of the new program of assistance. If USAID and the GRZ wish to continue or initiate other programs outside of the scope of the ZIHP-type program (e.g., the program for orphans and vulnerable children), other procurement mechanisms could be used.

USAID/PHN Office Management and Staffing (5.3)

The conclusion and recommendation in Section 4.2.3 (concerning the relationship between ZIHP and USAID/Zambia) is also relevant to this section, since it has an impact on overall management of ZIHP by USAID/PHN. For a CTO, the competing priorities between ZIHP management responsibilities and other technical and management responsibilities may simply be a function of overload. Part of the problem may also derive from gaps in internal coordination within USAID/PHN (e.g., limited communication among CTOs where there are important programmatic linkages). In any case, the competing priorities and/or overload factors detract from the collective potential for USAID/PHN to manage the complex ZIHP Program more effectively.

- **Recommendation:** USAID/PHN should reassess the management roles among its managers, and prioritize them to ensure the effective management and implementation of the ZIHP Program. If this requires the addition of staff who can focus on ZIHP Program management, this option should be considered. The recent decision to add a second person within USAID/PHN to help cover HIV/AIDS is one example of the

recognition of the problem and its possible resolution. Another option would be to add one or two staff members within USAID/PHN at the "Activity Manager" level. This would provide backup to the CTOs and ensure that day-to-day management activities are completed in a timely way, thus allowing the CTOs to focus on more complex issues.

Owing to time limitations in the overall assessment, financial management within USAID/PHN was not a specific focus of the assessment. However, one situation became apparent that suggests that USAID/PHN should assess adequacy and the equity of the overall allocation of funds among USAID/PHN programs, and in particular among the four ZIHP entities. The situation is complicated by the fact that, for a variety of reasons, the level and timing of funds allowances from USAID/Washington do not coincide with those planned for. This is a worldwide phenomenon, and includes three important dimensions: (1) funds are received later than they should be, (2) funding levels may be reduced from those anticipated (even earlier in the fiscal year), and (3) the earmarks[3] of funds actually received may be different from those planned. The ZIHP Program example has to do with the apparent shortage of USAID/PHN funds during the allocation of available program resources before the FY01 funds become available between now and September. The outcome thus far has been that at least partly because of the nature of the procurement mechanisms among the ZIHP entities, Abt Associates (the single contract) has been threatened twice during the last year with not having sufficient funds to continue operations, and they are currently in that position. Should the situation progress to the point where Abt Associates would have to interrupt the continuity of its support to ZIHP, it would have serious implications for the overall ZIHP Program.

- **Recommendation:** USAID/PHN should analyze its overall budgeting and allocation mechanisms to ascertain the source of the current difficulties, and should take measures to ensure that the situation doesn't continue.

[3] "Earmarks" are USAID's way of designating the purposes, or kinds of programs, for which the U.S. Congress has determined that overall health sector funds must be spent. Matching these earmarks to the funding of programs has become an increasingly difficult process, since the levels of specific earmarks of funds allowed may have changed significantly from the time programs were designed.

3. PURPOSE OF THE ASSESSMENT

3.1 Introduction

This assessment of the Zambia Integrated Health Program (ZIHP) was conducted from March 5 – 23, 2001. The Assessment Team comprised seven members, of whom three are Zambian officials within the Ministry of Health, the Central Board of Health, and the Churches Medical Association of Zambia (on secondment).

In summary, the assessment methodology comprised the following approaches. A more detailed description appears in Annex 3.

- A facilitated team-building exercise during the first day and a half;
- Presentations by each of the ZIHP component entities and the USAID Population, Health and Nutrition (PHN) Office;
- Two field trips (by splitting the Assessment Team) to obtain first-hand knowledge of program operations and implementation at provincial, district and community level;
- Meetings and/or Interviews with a wide range of health-related organizations and individuals both in the field and in Lusaka, with emphasis on both ZIHP and USAID/PHN representatives;
- Review of relevant documents;
- Data analysis and presentation; and
- Participant feedback and report revision.

As stated in the Scope of Work for the ZIHP Mid-term Assessment (Annex 1), the overall purpose of this mid-term assessment is twofold:

- to review the first two years of ZIHP implementation and provide an assessment of performance, lessons learned, and areas for improvement; and

- to provide USAID with input into the design of future assistance to the Government of Zambia after the end of the current ZIHP Program.

Notwithstanding the complex nature of the ZIHP Program described in Section 4, the assessment has tried to analyze the overall program at the mid-point of its implementation time frame, providing an overview of the program by looking principally at two of its programmatic dimensions: the five intermediate results (IRs) to be achieved, and the four principal technical areas being implemented. Thus it provides the USAID Mission, its partners and stakeholders with an analysis of ZIHP's progress and constraints during its first two years, and recommends a number of ways in which ZIHP can improve its performance. In addition, the assessment suggests approaches for USAID's future program of assistance in the health sector.

3.2 Assessment Objectives

The review of the first two years of the ZIHP Program has eight interrelated objectives:

1. Review and comment on the integrated vision of ZIHP. What have been ZIHP's achievements in carrying out the five Intermediate Results (IRs)? To what extent is ZIHP achieving results in the four technical areas of HIV/AIDS, malaria, child health and nutrition, and reproductive health? What could be done to improve performance?

2. Given the central role that behavioral change plays in the overall PHN Strategic Objective, review ZIHP's activities in this area and comment on their effectiveness. Have the behavioral change activities and approaches been well coordinated between ZIHPCOMM and ZIHPSOM? How have behavioral change approaches been integrated into the other ZIHP components?

3. Review and comment on the management structure of the overall ZIHP Program, as well as the management organization of the four ZIHP components.

4. Review the present structure of the four technical working groups and various sub-teams, how they currently work within ZIHP, and how they can be improved.

5. Assess the relationship of ZIHP with other key partners, including among others the CBOH, MOH, District Health Teams in Demonstration Districts, other donors, and private companies involved in workplace programs.

6. Review the effectiveness of ZIHP in providing technical assistance to various designated partners and make recommendation for ways to improve coordination.

7. Assess the relationship between ZIHP and USAID cooperating partners working in Zambia with Global Bureau field support funds. Is there adequate coordination of activities? Are they complementary?

8. Review the data provided by each component of the ZIHP program and comment on the quality of data provided to USAID for performance monitoring.

The second part of the assessment, looking at future directions for USAID assistance, has three specific objectives:

1. Provide recommendations for the future direction for USAID assistance in the PHN sector after the ZIHP program ends FY 02. What should be similar or different from the ZIHP model? Identify key issues that a follow-up design team would need to consider in the program development. Include discussion of PHN management burden for different options.

2. Comment on the option for extending the current ZIHP program by one year for a total of five years.

3. Review the overall management structure and staffing of the USAID/PHN Office and make recommendations for the future, taking into account anticipated funding levels over the next five years.

4. ASSESSMENT OF THE FIRST TWO YEARS OF THE ZIHP PROGRAM

In 1991 the Government of the Republic of Zambia (GRZ) embarked on a strategic program of health reform to achieve its ambitious vision of equitable access to cost-effective, quality health care as close to the family as possible. Within the overall context of health reform, the GRZ has reoriented highly centralized, vertical programs into decentralized, integrated programs. The major elements of the government's health reform program are:

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

Zambia's high rates of infant, child and maternal mortality, HIV infection and malaria prevalence are exacerbated by limited national resources to overcome these problems and achieve sustainable improvements in the health status of Zambians. The GRZ health reform program has the potential to achieve better health status, but requires focused attention to each of the major program elements.

The National Health Strategic Plan (2000-2005) was collaboratively developed by the GRZ and its stakeholders, and has become the focus for priority-setting and program implementation for the plan period.

During its current country strategic plan period, **USAID/Zambia's strategic objective for the health sector is "increased use of integrated child and reproductive health and HIV/AIDS interventions."** Five intermediate results (IRs) contribute to the achievement of this strategic objective:

- **IR 1:** Increased demand for PHN interventions among target groups.
- **IR 2:** Increased delivery of PHN interventions at the community level.
- **IR 3:** Increased delivery of PHN interventions by the private sector.
- **IR 4:** Improved health worker performance in the delivery of PHN interventions.
- **IR 5:** Improved policies, planning and support systems for PHN interventions.

This strategic objective and its intermediate results contribute directly and significantly to the national strategic plan, and fit within its overall priorities. In turn, the ZIHP Program, while it directly represents only about half of USAID/Zambia's annual financial contribution to the health sector, contributes directly and significantly to all five IRs, and thus to the overall strategic objective. In doing so, it addresses essentially all of the health reform elements listed above In addition, as discussed further below, each of the four ZIHP organizational entities contributes to more than one of the IRs through a complex collaborative process which reinforces the effectiveness of each entity and the whole program.

The ZIHP Program was developed in 1998 to help achieve USAID's strategic objective. ZIHP comprises four organizations which implement four major program components:

ZHIPCOMM has primary responsibility for assisting the Central Board of Health (CBOH) to develop comprehensive communication and training materials as part of its behavior change strategy designed to increase health promotion and prevention, and thus improve priority health indicators. Because of the focus on behavior change, ZIHPCOMM supports the efforts of all ZIHP components. Supporting the government's slogan, "It's you and me for better health," ZIHPCOMM strives to build the capacity of community members, NGOs and other civil society organizations to become partners with government in promoting healthy behavior and preventing disease. ZIHPCOMM is implemented by the Johns Hopkins University Center for Communication Programs, together with CARE International, Africare, and Manoff International.

ZIHPSERV assists the overall program to invest in the institutional capacity of the government, NGOs and the private sector to provide quality health care as close to the family as possible. At the community level, this includes both training a wide range of community-based agents and providing grants to NGOs to support community activities in the four priority health areas. ZIHPSERV also helps to improve government health worker performance and to strengthen the capacity of the District Health Management Teams (DHMTs) to supervise and support government and community health workers. In the private sector, this component addresses the health needs of employees and their families, and strives to increase private-sector involvement in providing health care services. ZIHPSERV is implemented by John Snow, Inc., together with CARE, Initiatives, Manoff and the International HIV/AIDS Alliance.

ZHIPSYS provides the enabling environment for ZIHP activities by helping the GRZ to develop essential policies, guidelines, and national standards, and by helping provinces and districts to implement them. In addition, ZIHPSYS provides assistance in developing and implementing many cross-cutting systems in the areas of planning, data management and use, quality improvement, supervision, and logistics management. Finally, ZIHPSYS has formal responsibility for coordinating the four components of the program. ZIHPSYS is implemented by Abt Associates, Inc., together with Pathfinder, Initiatives, the American Manufacturers Export Group and the University of Zambia.

ZIHPSOM is responsible for the several related elements: the social marketing of products, behavior change, communication, and the training of certain private health care providers and agents. ZIHPSOM's principal role is to expand the commercial availability and affordability of subsidized health products, including contraceptives, male and female condoms, insecticide treated nets (ITNs), and a chlorine solution for treating drinking water. ZIHPSOM is implemented through the Society for Family Health and Population Services International.

In its overall integrated approach, the ZIHP Program focuses on four main technical areas:

- HIV/AIDS
- Malaria
- Child health and nutrition
- Integrated reproductive health

While ZIHP provides assistance to Zambia's health programs at national, provincial, district and community levels, special attention is given to twelve demonstration districts which were selected jointly by the GRZ and USAID. Focusing on these demonstration districts enables ZIHP to help the GRZ to identify successful implementation strategies, test new methodologies, and achieve health impact at the community and household level, especially within these four technical areas.

4.1 Focus on the ZIHP Program

As noted earlier, the ZIHP Program has multiple dimensions by which it can be observed and analyzed:

- By intermediate result
- By technical area
- By intervention
- By geographic area
- By demand

The Assessment Team was asked to review ZIHP's first two years of implementation by both intermediate result – the principal way in which USAID/Zambia measures its impact in achieving results – and by major technical area. The following two subsections provide these two different perspectives on the ZIHP Program. However, within these two frameworks one can also view the other dimensions, and see how all five interrelate in overall program implementation.

Because of the scope and level of detail in both the intermediate result and technical area sections, each section is divided into three subsections: Introduction, Key Findings, and Conclusions and Recommendations. Since later sections are generally less complex and tend to be shorter, they have a simpler presentation format.

4.1.1 Program Assessment by Intermediate Result (IR)

4.1.1.1 IR1: Increased demand for PHN interventions among target groups

Introduction

ZIHP uses complementary strategies to increase demand, including social marketing to increase product demand, generic communications campaigns through mass media to increase overall awareness of the need for healthy behavior, and local-level training in community mobilization and health issues.

This integrated health promotion system affects behavior through changing attitudes to health as well as by creating direct demand for services and products. The behavior change communications component addresses the health issues covered by the Essential Health Package, the social marketing component promotes products that make it easier for individuals to act on these messages, while Neighborhood Health Committee Members, health workers, peer educators and community distributors are trained to deliver information and services in the same areas.

Key Findings

Social Marketing. ZIHP's social marketing program, ZIHPSOM, implemented through the Society for Family Health (SFH), is unusual in having a wide product range. The program markets the Maximum male condom; the Care female condom; one untreated and one treated insecticide treated net (ITN) (PowerNet and Safenite), PowerChem re-treatment tablets; Safeplan contraceptive pills; and Clorin water treatment solution. SFH expects to add a multivitamin pill to the product line in 2001. Products are marketed by a sales force headed by a representative in each province, through brand advertising in the mass media, and through outreach by peer educators and community and employer-based distributors.

Products are targeted at different audiences, with Maximum targeted at 15-24 year old youth, Care at educated women and men in steady relationships, and ITNs and Clorin targeted at the community level, with ITNs targeted primarily at pregnant women.

The following table shows the increase in product sales over the last two years:[4]

Product	1999	2000
PowerNet	12,097	~40,000
PowerChem	810	~5,000
Clorin	34,416	568,836
Safeplan	81,216	445,200
Maximum	6,577,337	8,609,233
Care	10,944	73,560

This national sales pattern is reflected in the target areas. For example in Copperbelt Province, sales of Maximum condoms went up from 375/month in 1999 to 450/month in 2000 and Clorin sales have increased to 21,600. In the border areas where ZIPSOM collaborates with World Vision to reach target groups, it has exceeded the target of 70,000 condoms sold in four of the five sites.

ZIHPSOM's distribution system is organised to achieve national coverage and reach remote areas. There is an SFH representative and office in each province, which supervises a team of sales agents. Different distribution strategies are used for different products, with priority given to a range of channels, as follows:

Product	First channel	2nd	Additional	Additional
ITNs	Clinics	Sales agents	Retailers	
Clorin	Health centre	DHMTs	NHCs/CBDs	School clubs
Safeplan	ANC/MCH clinic providers	CBDs/NGOs	EBDs	Wholesalers
Maximum	Wholesalers	NT outlets	CBDs	NGOs
Care	Wholesalers	Saloons		

The social marketing distribution system is supported by (1) brand advertising; (2) interpersonal communication using drama, school-based programs, local radio, and a mobile video unit based in Lusaka; and (3) peer educators who promote the full range of products in collaboration with health clinics and communities. In the year 2000, about 40 peer educators, based in Lusaka and six of the provincial capitals, gave about 2,000 health presentations, reaching over 100,000 people. In Kitwe and Ndola, peer educators support health clinic staff by regularly visiting growth monitoring posts to deliver health education messages.

Communication Strategies for Health. A key component of the communication strategy is ZIHP's participation in the mass media component of the Central Board of Health's Better Health Campaign. The campaign promotes the health reform agenda through supporting a new focus on preventive behaviours and individual responsibility for health. The current mass media campaign, launched in 2000, includes focused TV and radio segments on "Your Health Matters"; a thirty-minute talk show, "Lifeline"; a regular newspaper column, "To Your Health"; and broadcast of the Soul City information program. The campaign is jointly funded by the CBOH, which supports airtime for this and other ZIHP mass media products, and by ZIHP for production costs.

[4] ZIPH Annual Report: January 1, 2000- December 31, 2000. Sales are not given for Prolact, as the product will be discontinued owing to its unsuitability for distribution in an AIDS epidemic.

ZIHP's promotion of the bi-annual Child Health Week is a good example of the synergistic effect of interpersonal and mass media interventions. The promotion approach used mass media spots, posters and leaflets for health clinics and other locations, information cards for health workers on vitamin A, malaria, growth monitoring, and immunization, community events, and provision of public address systems to all districts. Health clinics reported that the promotion successfully increased coverage of vitamin A from 30% to 90%. In this case the community level was the main motivator for increased demand, with 65% of users hearing about Clorin from the health center network and mass media reinforcing the message.[5]

Youth Focus. ZIHP has intensified communication targeted at youth, particularly in relation to HIV/AIDS. The HEART campaign "Helping Each Other to Act Responsibly Together" is targeted at unmarried youth aged 15-19 and at all youth aged 9-14 in both urban and rural areas. The behavior change strategy is to encourage youth to either abstain from sex or to use a condom each time they have sex. The campaign was based on substantial research indicating that 84% of youth are sexually active by the age of 18, but the majority (64% girls and 70% boys) do not believe they are at risk for HIV. 84% of youth did not use a condom last time they had sex. ZIHPSOM's social marketing program for Maximum targets older sexually-active youth, aged 15-24; ZIHPSOM also targets youth through its Club New Teen Generation radio program and through a new project "SISTA" aimed at girls.

Channels for the HEART campaign include mass media advertising in TV, radio and print, fact sheets on youth, special events, peer education and work with secondary audiences that influence youth. The "Youth in Crisis" campaign was also recently introduced to target the general population to increase awareness of the impact of HIV/AIDS on youth.

ZIHP has taken an innovative approach to involving youth in communication for youth through grants to a consortium of youth organisations headed by the Youth Activists Organisation (YAO). The groups' activities include working with artists through "Africa Alive", producing "Trendsetters" newspaper (with a circulation of 85,000-90,000), a planned newspaper in local languages for primary school youth in rural areas, youth football camps and working with schools and church organisations. YAO reports that it reaches 7000 persons a week with youth activities. One indication of success is that that these organizations have attracted partners: UNICEF has funded a special edition of Trendsetters for schools, YAO is working with the Peace Corps and the Zambia Football Association on the youth camps.

The issue of promoting condoms for youth has been controversial, particularly in regard to messages aimed at young, sexually active women. Recently, television spots on condom use for women were withdrawn after complaints from church leaders.

Slogans and Messages. One of the features of ZIHP's demand creation is the successful use of slogans and symbols to create awareness and internalization of health messages. Examples are "You and Me for Better Health", in the Better Health Campaign; the Red Ribbon and White Ribbon campaigns for HIV/AIDS and Safe Motherhood; the HEART logo and the slogan "Abstinence: Ili Che" for youth. These symbols and slogans appear to have increased recognition among the general public, and have helped in establishing these health concerns as part of each person's social context.

Impact of Mass Media. Survey results indicate high exposure to and interest in these mass media interventions For example, 88% of television viewers and 67% of the radio audience was exposed to the Better Health campaign and over 10,000 letters have been received

[5] Diarrheal disease prevention survey: September 2000.

from viewers.[6] Groups of mothers and NHC members interviewed in Copperbelt Province also said that they listened to radio programming on health, specifically citing "Your Health Matters." A 1999 follow-up survey on the HEART campaign determined that, of the 65% of youth surveyed that watch television, 62% of boys and 68% of girls recalled the spots; and of those, 56% of boys and 50% of girls took action: 20% decided to stay abstinent; 18% talked to friends.

ZIHP's recent 2000 Youth Survey has documented a correlation between campaign exposure and sexual behavior. Of those who had ever used condoms, 38.6% of men and 48.7% of women had viewed campaign advertisements compared to 22.1% of men and 25.5% of women who had not seen the campaign. Condom use during the last sex act was also correlated with viewers: 32.4% of male and 35.6% of women who used condoms had seen the campaign, while only 17.6% of men and 16.6% of women condoms users were non-viewers. Campaign exposure is also positively related to abstinence and to a return to abstinence (i.e., not sexually active in the last six months).[7]

Research also indicates the value of brand promotion in supporting demand for condoms. Higher levels of exposure to condom advertising are associated with higher condom use.[8] The ZIHP 2001 youth survey reported that 68.3% of youth who had ever used condoms had been exposed to Maximum advertising, compared to 46.1% of youth who had not been exposed to it.

Neighborhood Health Committee and Institutional Training. A significant strategy in increasing demand has been to empower communities and institutions to respond to health issues. ZIHP has trained NHC members in each health center catchment area in community mobilization and communication skills through the Participatory Learning in Action (PLA) Process. In collaboration with the DHMTs, ZIHP trained 348 CHWs as trainers, who in turn trained 5394 NHC members. ZIHP also developed a radio distance learning package for NHC members in which 10,000 have enrolled. These interventions have raised awareness of selected health issues among the community.

This strategy is supported by peer education programs to reach the community. All 12 districts have trained a total of 390 community volunteers who conduct integrated health promotion activities linked to the district health services. In addition, EBDs (in both schools and workplaces) and social marketing peer educators promote preventive health.

Materials Development. Campaigns and training have been well supported by development of materials, including an IEC kit for NHC members, training materials, fact sheets, posters, brochures, and videos. Particularly noteworthy is the Family Planning Counseling Kit and companion training video, which presents role models for positive provider attitudes in a realistic and entertaining way; 140 copies of the FP counseling kit were distributed. It had been received by most though not all hospitals visited during the assessment; several health providers said they found the "profiling" approach helpful.

However, there were concerns from one government agency that they had not been adequately consulted in the development of materials, which led to having to make changes at a very late stage and created a certain amount of bad feeling.

Evidence of Impact. There is some early local evidence of impact. After Clorin was introduced in 1998, diarrheal disease rates recorded in Luangwa urban district in comparable quarters of the year decreased from 200 in 1998, to 54 in 1999, and to 34 in

[6] Information from ZIHPCOMM presentation
[7] Presentation on the 1999 and 2000 Youth Surveys.
[8] 1999 Youth Survey

2000. Similarly, after ITNs were promoted in the area, the Luboto Clinic in Ndola recorded a drop in malaria cases from 7800 in 1998, to 7000 in 1999, and to 4,800 in 2000. However, these decreases corresponded with a period when mining companies were also spraying houses, so the ITNs may not have been responsible for the full impact measured.[9]

There is also evidence of increased demand for services. ZIHP reports that modern method use is increasing, with a 100% increase in new acceptors in targeted areas and continuing clients being sustained. The Mindolo Clinic in Kitwe District estimated that coverage of women at weighing posts supervised by the clinic went up from 65% in 1999 to 78% in 2000. Comparison of knowledge of the protection factor of ITNs is higher in intervention districts than control districts (37%-43% versus 18%-19%), and the percentage reporting having a net in the household is also higher (14-29% intervention versus 1-3% control).[10] However, quantitative data are limited.

Conclusions and Recommendations

ZIHP partners with CBOH in developing the various media campaigns and in supporting CBOH interventions. ZIHP also works with other government agencies and organizations, such as the NMCC, NFNC, and the General Nursing Council in developing materials. Collaboration has generally been good, though there have been problems with the NMCC and NFNC, who have at times felt side-tracked by ZIHP. Specific issues noted by these agencies were poor communication, the lack of sharing annual plans, and some problems in materials development with one agency. However, the CBOH was strongly positive about the quality of ZIHP's communication products, referring to the program as "a star."

ZIHP's integrated approach to increasing demand through a combination of social marketing, mass media, and community-level interventions has achieved a great deal in only two years. It has been successful in increasing national awareness of health issues and influencing attitude and behavior change, resulting in increased demand for health products nationally and for some health services in target areas.

ZIHP has used multiple channels and messages to influence community norms and reinforce health attitudes and behaviors, including the use of continuous and high quality mass media messages and campaigns. The mass media HEART campaign, for example, received a national award. ZIHPCOMM sees these interventions as both "household-level" and national-level strategies, since they reach the individual in his or her own home.

- **Recommendation:** ZIHP's collaboration with the CBOH in behavior change programs should be continued at the same level of investment during the remainder of the program.

Community mobilization training has successfully empowered NHCs to take a new proactive role in informing and organizing their communities around health issues. This role is reinforced through the distance education course for NHCs. However, there was a shortage of IEC materials at the health centers and NGOs visited.

- **Recommendation:** ZIHP should explore ways to continue to update and motivate peer educators and other community health workers, for example by using the NHC distance education model. ZIHP should also give priority to the plans to institutionalize and decentralize the distribution of materials in the public sector and consider supporting a central resource point for materials and information possibly based in a lead NGO. The team also raised the issue of whether more print materials in local languages should be

[9] Reported in field interviews in Ndola and Kitwe, March 2001

[10] Data provided by Society for Family Health

developed for literate but non-English speaking health workers. It is understood that ZIHP has assessed this question and takes the position that local-language materials would not be cost-effective.

ITNs were introduced into some communities nearly one year ago, but re-treatment issues were not discussed by NHC members during our field visits. We also found some stock-outs of re-treatment tablets.

- **Recommendation:** The Assessment Team understands from ZIHP that materials on re-treatment have been developed and that ensuring re-treatment of ITNs has proved to be a difficult issue worldwide. In Zambia, other malaria net programs that have tried to promote re-treatment have only achieved 1% re-treatment rates. Recognizing these problems, the team is pleased to note that promoting re-treatment after 3 washes will be a priority for ZIHPSOM this year, as our field experience confirmed that NHCs need to be more aware of its importance.

The social marketing intervention has been highly effective in introducing new products, particularly ITNs and Clorin, as seen in the increased sales in districts visited. However, the team noted some stock-outs (ITNs in some sizes, Clorin bottles) at one ZIHPSOM district office and limited supplies held by some CBDs and EBDs of some products (condoms, contraceptives) particularly in rural areas. One problem identified was the difficulty small NGOs face in paying for social marketing products in advance.

- **Recommendation:** Communication with ZIHPSOM has clarified the fact that distribution of products at the clinic level is primarily the responsibility of the DHMT and that initial product provided on credit to the DHMT, NGOs, CBDs, and EBDs must be paid for before they can get more stock. ZIHP may want to discuss how best the different arms of ZIHP can collaborate in working with DHMTs to improve logistics, distribution, and financial planning to minimize such stock-outs. In addition, the TSOs, NGOs, and CBOs funded through the NGO grants program could benefit from training in how to assess needs and fund products. It will also be important to ensure that supplies in ZIHPSOM district offices are adequate to meet the rapidly increasing demand.

- **Recommendation:** The team appreciates the difficulty in reaching remote rural communities and urges ZIHP to continue to focus on these needy areas. ZIHP should consider the cost-effectiveness of investing in a second mobile video unit, to be based in the Kitwe/Ndola area, in addition to the unit based in Lusaka.

4.1.1.2 IR2: Increased delivery of PHN interventions at the community level

Introduction

Between 1980 and the mid-1990s, the health status of the Zambian people worsened and was marked by increased child/infant and maternal mortality, soaring rates of HIV/AIDS and deteriorating public health services. In response, the Government of Zambia embarked on an innovative health reform and decentralization process to bring equitable access to cost-effective, quality health care to Zambian families. Essential to the success of the Health Reform Program is the improved delivery of PHN services at the community level. The ZIHP project has defined these key interventions to be:

- the community's ability to identify and solve problems;
- an improved relationship between the health center and the community;
- the delivery of PHN services by NGOs in high-risk areas;
- improved referral systems and improved intersectoral partnerships.

Key findings

To enhance the capability of community to solve problems, ZIHP has focused upon: reviewing district Action Plans; reviewing PLA activity plans; facilitating peer review and learning in demonstration districts; and expanding the use of Community Health Innovative Funding. To improve health center an community partnerships, ZIHP focuses upon: curriculum development and education for health workers and CBAs; development of HC and community training packages for community counselors; capacity building within the DHMT for refresher courses for community based cadres; improved DHMT supervision and coordination of HC/CBA activities; and increased access to PowerNet and Clorin through community-based sales. To improve NGO delivery of PHN interventions in high risk areas, ZIHP has engaged the following: building the capacity for NGOs in demonstration districts; strengthening the technical and financial capacity of CBOs; developing CMAZ capacity to support NGO activities; and increasing the access to social marketing products through NGO-supported sales agents. ZIHP plans to improve the referral systems and intersectoral partnerships through initiatives in demonstration districts.

Conclusions and Recommendations

This IR, *increased delivery of PHN interventions at the community level*, is one which naturally integrates key findings, conclusions and recommendations of other IRs, especially IR3 (*increased delivery of PHN interventions by the private sector*) and IR5 (*improved policies, planning and support systems*). In reading this section the reader should keep in mind these interrelationships, and recognize that some conclusions and recommendations are also shared with the other two respective IR sections below (4.1.1.3 and 4.1.1.5).

Action Plans and PLA Community Activity Plans. ZIHP has been highly effective in the development and reviewing of demonstration district Action Plans and in the development of PLA activity plans at the community level. In the Eastern, Central and Copperbelt Provinces, DHMT staff and leadership have appreciated ZIHP's input into the process. ZIHP inputs have come primarily in the form of training of community-level personnel and the provision of technical assistance to the planning process.

In addition to the development of the initial draft plans, the Zambian planning process is viewed as a series of negotiation steps between various levels of the health sector. There were concerns expressed by district-, provincial- and national-level officials regarding the overall participation of ZIHP in the "negotiation process" involving the role of partners in the development of final plans and budgets. ZIHP was seen as coming into the preparation of the Action Plan at the national and district levels with an already prepared menu or agenda of activities (particularly training, social marketing, IEC and high-level technical assistance). The ZIHP menu of activities was not always seen as matching the priority needs of the province, district or community, particularly in providing balanced "capacity" and "operational" needs and their associated budgets to support the ZIHP activities.

- **Recommendation:** ZIHP should continue the early inputs into the improvement of planning skills at the level of the community, district and national level. However, ZIHP should consider expanding its support for the service-delivery-related activities of the respective Action Plan. For example, ZIHP inputs into the Action Plans should assure that capacity enhancement skills being developed in IMCI and IRH training initiatives can be fully utilized. If the new skills can't be fully utilized in carrying out programs for lack of other resources, the health workers can't be fully effective, and may lose the skills quickly. To help ensure program impact, continuity and sustainability, overall program resource needs must be met. The GRZ, USAID and ZIHP should assess the reasons that needed backup support (drugs, basic equipment, transport, etc.) are not available,

and should provide supplemental resources from among available options. At the same time, ZIHP should work with DHMTs and NHCs to encourage longer-range planning to make sure that resources that could be provided by them will be available when needed.

Improved relationship between the health center and the community. ZIHP has been instrumental in improving the relationship between health centers and communities primarily through improved training of CHWs and NHCs, expanded planning with NHCs, more frequent supervision of CHW/NHC activities, effective IEC materials, expanded social marketing products, increased funding for selected NGOs, and increased operational support for Child Health Week.

The increased interaction between communities and health centers has increased the expectations of the communities; they now seek improved access to quality health services, health-related transport and basic referral services.

- **Recommendation:** To help ensure program impact, continuity and sustainability, overall program resource needs must be met. The GRZ, USAID and ZIHP should assess the reasons that needed backup support (drugs, basic equipment, transport, etc.) are not available, and should provide supplemental resources from among available options. At the same time, ZIHP should work with DHMTs and NHCs to encourage longer-range planning to make sure that resources that could be provided by them will be available when needed.

Facilitating peer review and learning in demonstration districts. ZIHP has provided high-quality technical assistance to district and community level programs, particularly in the areas of training personnel (PLA, IMCI, IRH, policy, planning and social marketing). In districts with staff shortages, this technical assistance has been especially appreciated. ZIHP assistance has been instrumental in the introduction and development of innovative systems for district/community planning, IEC material development, financing, social marketing and supervision. For example, ZIHP has had key inputs into:

- Pre-paid care at health centers and a key mission hospital in Chipata District;
- Social mobilization and marketing of ITNs, Clorin for water purification and condoms/contraceptives;
- The process of policy development and planning;
- Improved training curriculums and training courses;
- Improved capacity of a limited number of local NGOs; and
- the implementation of Child Health Week, child health, nutrition, malaria, HIV/AIDS and IRH services at the community/district levels.

Despite these key technical assistance inputs, the districts and communities are not fully aware of the process for accessing and developing peer review and learning resources from ZIHP. There is not “one-stop” shopping for the panoply of ZIHP activities. In addition, CBOH, PHMT, DHMT and NGOs/communities have no idea of the costs of developing/implementing such activities. This greatly limits the determination of the cost-effectiveness and replicability of such initiatives at the district/community level.

- **Recommendation:** ZIHP should work towards creating a greater awareness in the health sector of the array of ZIHP technical assistance capabilities, and where possible should facilitate “one-stop” contacts for all ZIHP services in specific geographic areas.

- **Recommendation:** ZIHP should introduce basic cost-effectiveness, cost-efficiency, cost-benefit and sustainability skills into the peer review, technical assistance and learning methodologies being implemented in all demonstration districts.

Improved technical capability of CHWs and DHMT staff to provide PHN services at the community level. DHMT officials have indicated that ZIHP training materials and training programs have made a major contribution to the improved technical capability of CHAs and DHMT staff. Some 240 TOTs and 5300 community health agents/workers have been trained to enhance the PHN services in some 2200 NHCs.

Although ZIHP-trained staff indicated their appreciation for their improved technical skills, DHMT staff and health workers alike have also reflected a need to be provided with increased drugs, equipment, transport and communications in order to fully utilize newly acquired skills and to reach the full potential for health service provision

- **Recommendation:** To help ensure program impact, continuity and sustainability, overall program resource needs must be met. The GRZ, USAID and ZIHP should assess the reasons that needed backup support (drugs, basic equipment, transport, etc.) are not available, and should provide supplemental resources from among available options. At the same time, ZIHP should work with DHMTs and NHCs to encourage longer-range planning to make sure that resources that could be provided by them are available when needed.

Delivery of PHN services by NGOs in high-risk areas. ZIHP has identified a number of effective national-level NGOs to facilitate the delivery of PHN services in both high-risk and hard-to-reach areas. At a national level, key NGOs such as the Churches Medical Association of Zambia, Africare and World Vision International are working with ZIHP to provide and monitor grants to local NGOs and CBOs. In addition, ZIHP is supporting a number of key NGOs, including Africa Alive and Trendsetters, to provide a national IEC platform to disseminate key health messages, particularly to youth groups.

At the district and community level, ZIHP has identified and provided support to mature, church-related organizations and newly emerging “specialized NGOs” such as the HIV/AIDS organization Thandizani in Lundazi. These efforts have begun to extend the delivery of services to remote communities in the areas of child and reproductive health, HIV/AIDS and a variety of IEC initiatives. In addition, the social marketing activities of SFH with these local organizations has significantly extended the distribution of ITNs, Clorin and contraceptives.

In several meetings with more than 20 local NGOs in Eastern Province, it was clear that many established NGOs knew of the existence of ZIHP, but did not have an appreciation of the multiple activities supported by ZIHP or the appropriate way to become more involved with ZIHP-funded activities. In the words of one district level NGO, “ We don’t really know what is happening with ZIHP”. NGO leaders attributed this lack of knowledge to the absence of a full time representative in the district for all ZIHP components.

- **Recommendation:** In order to more rapidly reach high-risk populations, ZIHP must develop more frequent and effective communication and dialogue to expand the involvement of local NGOs in ZIHP-supported areas of HIV/AIDS, child health and nutrition, IRH and malaria.

- **Recommendation:** In districts where ZIHP has selected a “lead” NGO, ZIHP must give increased attention to the suitability of the selected NGO. Many NGOs which have been selected as initial agencies for ZIHP support, particularly at the district and community levels, tend to be highly effective, one-dimensional organizations and cannot be effective models or fully represent the multi-faceted capabilities of ZIHP to other NGOs. ZIHP needs to extend assistance to the widest possible spectrum of NGO organizations within the technical areas of the program.

- **Recommendation:** As ZIHP is not likely to open offices in each demonstration district, ZIHP should give consideration to developing the capacity within local government entities, particularly the DHMT, to recruit/mobilize, managerially strengthen and provide grant support to local NGOs to reach high-risk areas.

Improving the functioning of the referral systems and intersectoral partnerships. ZIHP has been effective in strengthening the capacity of the DHMT to coordinate and facilitate community-planning inputs into the District Action Plans. This occurs primarily through the development of PLA skills at the community level, and through provision of technical assistance to the Action Plan process.

ZIHP has been instrumental in improving the supervisory capacity of DHMTs for selected PHN interventions, particularly in Child Health Week and in the social marketing of ITNs, Clorin, condoms and contraceptives.

ZIHP has been less effective in the provision of ongoing supportive supervision of health personnel to achieve continued improvements of the skills of the ZIHP-trained personnel in IMCI and IRH. Numerous persons trained by ZIHP in these areas expressed the need for continued supportive supervision to meet the challenges of complicated IMCI and IRH conditions in the community.

ZIHP has not had a noticeable impact on the improvement of the health care referral system for clinical care from the community to the district hospital. Basic improvements to the clinical care continuum are considered vitally important by all members of the health care team, from the NHC to the health center to the district hospital and to the DHMT.

- **Recommendation:** ZIHP should modify the training approach for district- and community-level persons to include a more vigorous system of high-quality supportive supervision which will ensure a constant improvement of essential skills in community- and district-level personnel with regards to HIV/AIDS, child health care and nutrition, IRH, and malaria.

4.1.1.3 IR3: Increased delivery of PHN interventions by the private sector

Introduction

An important element in the Government of Zambia's Health Reform strategy is the promotion and expansion of employer-based or workplace financing and delivery of health services. Under Intermediate Result 3, ZIHP is working to complement the government strategy through increasing access of STI/HIV/AIDS, reproductive health, child health and nutrition, and malaria-related services in the private sector.

ZIHP is expanding the supply of private sector preventive and curative health services through the following activities: social marketing, an employer-based health program, FACEAIDS, reaching out to traditional healers and private providers and improving the enabling environment for public-private partnerships.

Key Findings

ZHIP has significantly increased the delivery of PHN interventions by the private sector.
Many activities in this IR are quite nascent and require further time to become established and make sufficient progress to measure their efficacy.

Social Marketing. ZIHPSOM, operating through the Society for Family Health, markets a wide range of products including Clorin water purification solution for the prevention of

diarrhoeal disease; PowerNet and Safenite, mosquito nets for malaria prevention, and PowerChem re-treatment kits; Safeplan birth control pills for pregnancy prevention; and Care female condoms and Maximum male condoms for prevention of pregnancy and STI/HIV/AIDS transmission. In 2001, SFH will launch a micronutrient supplement called Vibrant! in order to combat anemia.

Social marketing has increased the supply of affordable PHN products in Zambia, through increasing the number and variety of outlets where products can be purchased. For example, 39% of all private sector outlets in the country carry Maximum condoms.
Similarly, Safeplan has traditionally been available through the public sector, but through social marketing, Safeplan can usually also be found in the private sector (sometimes even during public-sector stockouts). Therefore, social marketing has increased the number and variety of outlets where Safeplan is available, thereby effectively increasing access. Likewise, products such as Clorin and mosquito nets, if not available through social marketing, would not be affordable or accessible for the majority of Zambians.

Employer-based Programs. These programs operate in eight out of the twelve demonstration districts, and focus on workplaces with greater than 25 employees. Of the 321 workplaces identified which meet the criteria, most are private businesses and there are a handful are government offices. So far, 187 employees in 143 of the 321 sites have become employer-based distributors (EBDs), and have been trained to provide selected family planning services, distribute condoms, and provide child health and HIV/AIDS prevention information. Through these EBDs ZHIP is reaching approximately 94,000 people. EBDs significantly increased the sales of oral contraceptives and male condoms in the first three quarters of the year 2000. Unfortunately, there was a problem supplying the agents with commodities in the fourth quarter, causing a decline in distribution in this period. In several instances, EBDs educated through this program have had the initiative to work outside their workplaces in their communities as well.

FACEAIDS. Though similar to the employer-based program, FACEAIDS focuses on HIV/AIDS issues. FACEAIDS offers the following package to companies and their employees: education and awareness building on HIV/AIDS, education on prevention of HIV/AIDS, training of peer educators, distribution of male and female condoms, information on VCT, information on family planning and double protection, technical assistance in the formulation of an HIV/AIDS policy for the workplace, and promotion of the red ribbon campaign. Because this program is new, there are no significant results. However, one early program success is the coordination of messages and curricula with others doing similar programs, including DFID and PPAZ. Also, FACEAIDS will initially reach a small population but has the potential to have a much larger impact and be a very effective distribution point for condoms. One major strength of FACEAIDS is the substantial in-kind contributions of the companies (in terms of both financial and human resources), ensuring their commitment to the program.

Traditional Healers. ZIHP has identified 144 traditional healers with whom to work. A small amount of research has been done to confirm the importance of working with this group and to identify the best ways to work with traditional healers. It has been discovered that 80% of patients pass through traditional healers before they present in the formal health sector. It has also been documented that health center staff and traditional healers don't trust one another. Even so, traditional healers refer patients to the health clinics and health care workers refer patients to traditional healers (especially for problems like STDs). A simple referral letter, to facilitate traditional healers in referring patients to health centers, has been designed and is currently in use in some districts. A training manual is being developed, with input from traditional healers, and will be used to train them in the near future.

Private Providers. Nurses comprise 70% of health personnel in Zambia and can be found even in the most remote areas of the country. This makes them an ideal cadre for reaching large sections of the population with promotive, preventive and curative services, either through the public or private sectors. However, it is difficult for nurses to work in the private sector due to lack of capital. Also, the Nurse Midwives Act of 1997, designed to allow nurses to work in private practice independent of a practitioner, has only just been signed into law. There are a small number of private nurses, 118 identified by ZIHP, who are currently working in the private sector in Zambia. ZIHP will offer these nurses business management and marketing skills training. ZIHP also works with the General Nursing Council and has helped them to develop a three-year strategic plan.

ZHIP has identified 330 private medical practitioners in the country. (It is unknown what percentage of the population are reached by private sector practitioners because they aren't currently required or able to record their contributions to national health service statistics.) ZIHP has reasoned that it is likely that most private practitioners have not had their skills updated for many years. Therefore, for those who are willing, ZIHP hopes to provide an update training with emphasis on counseling skills, since many are offering HIV testing. While an ideal amount of time for such an important training might be 4-6 weeks, many practitioners could not or would not be willing to forgo income for that length of time by being absent from their offices. Therefore, ZIHP is looking for innovative ways of offering the training which would be acceptable to this cadre.

Enabling Environment for Public-Private Partnerships. ZIHPSYS will help to develop a system whereby private providers can track service data of interest to the GRZ and be able to feed it into the national HMIS system. In co-ordination with the GRZ and professional organizations representing private practitioners, ZIHPSYS will also help develop the policies, regulations and guidelines to support sustainable public-private partnerships. Though a ZIHP/CBOH private-sector working group has been agreed upon by both parties to work on these issues, there have been delays in forming the group and the onset of collaboration to address these issues.

Conclusions and Recommendations

Targeting the private sector has been an effective way for ZIHP to increase access to PHN services.

- **Recommendation:** All private-sector programs undertaken by ZIHP have the potential to increase or are already effectively increasing access to PHN services, and should therefore be continued or scaled up.

In some of the districts visited there were stockouts of certain products, especially ITNs and certain brands of contraceptives. In addition, at the chlorine production factory in Kitwe, they had run out of bottles and had to stop packaging Clorin to wait for bottles to be delivered from Lusaka.

- **Recommendation:** ZIHPSOM is currently working to eliminate such problems. They should continue modifying the forecasting system and addressing other problems to ensure a constant supply of products.

Private practitioners and traditional healers have been under-utilized as distributors for socially marketed products.

- **Recommendation:** ZIHP should consider innovative ways to increase utilization of private practitioners and traditional healers as outlets for socially marketed health products.

Employer-based programs and the FACEAIDS project are both effective workplace initiatives with peer education and distribution of reproductive health commodities.

- **Recommendation:** FACEAIDS could be strengthened through a stronger focus on family planning and the employer-based program could be strengthened through a stronger focus on HIV/AIDS education and prevention. These programs should share materials and lessons learned.

The peer educators in the FACEAIDS and employer-based programs are not being effectively supervised.

- **Recommendation:** ZIHP should develop mechanisms that will assist the DHMT to improve the supervision of peer educators.

It is rare for traditional healers to participate on NHCs or as CHWs.

- **Recommendation:** The traditional healers' curriculum should be developed by adapting the CHW curriculum. This would not only ensure that the traditional healers are reinforcing the messages of the CHWs, but would also be realistic and cost-effective.

Private medical practitioners are an untapped resource in Zambia. Training of these practitioners is crucial but takes them away from their jobs for a long time.

- **Recommendation:** ZIHP should find a way to make a training program acceptable to private providers without taking them away from their jobs for long periods of time. Consider evenings, weekends, self-paced distance learning, etc.

Policy issues and guidelines for interventions in the private sector are stagnating.

- **Recommendation:** ZIHP should continue to support the CBOH in the development of private-sector policies and guidelines.

4.1.1.4 IR4: Improved health worker performance in the delivery of PHN interventions

Introduction

ZIHP's strategy is to work with CBOH, DHMTs and the General Nursing Council to strengthen the systems for ensuring a high level of performance by health workers[11]. Where such systems already exist, ZIHP aims to strengthen those that have the best prospects to support high-performing health workers. In addition, some efforts are also being directed towards developing and testing sustainable approaches for human resources development in the twelve demonstration DHMTs.

By the end of the ZIHP Program, systems for assuring pre-service training, in-service training and supervisory systems consistent with the delivery of high-quality services should be well established and functioning effectively.

Key findings

[11] ZIHP Annual Report 2000 Final draft

From its meetings with various stakeholders including ZIHP, GNC, CMAZ, Provincial Health Management Teams, District Health Management Teams, Health Center staff, Neighborhood Health Committees, the Assessment Team found that ZIHP has been working to improve health worker performance through improving pre-service training, in-service training, and supervisory systems.

Improving pre-service training. ZIHP has undertaken the following activities to improve pre-service training systems[12]:

- The General Nursing Council's 3-year strategic plan (2000-2002) was completed together with the first-year plan of action. ZIHP awarded the Council a $160,000 grant to facilitate implementation of Year One activities, with focused support to training institutions and intensified Council centered capacity building.
- A Training Needs Assessment of training institutions was successfully undertaken and results disseminated to CBOH, MOH and other stakeholders.
- A system for review of nurse/midwifery curricula has been established. Review of the Nurses and Midwifery curricula has commenced. This review will consider the results of Training Needs Assessment, Rapid Skills Assessment, the Essential Health Care package, and issues from the senior Nurses and Midwives consultative meetings and those from the dissemination of the Code of Conduct.

Improving in-service training. ZIHP has also undertaken a program of Integrated Competency-based Training (ICT) to improve in-service training systems. By December 2000, forty-seven first-level health workers drawn from health centers throughout the country successfully completed an initial training program, which was used to validate the Integrated Competency-based Training modules. The results of the ICT field test underscored the need for appropriate trainer selection, thorough trainer preparation, and standardization and further editing of the ICT training materials.

Follow-up of the forty-seven health workers trained in ICT showed positive results of the application of acquired skills in the provision of quality health care services, utilization of HMIS data, and increased confidence in working with communities. 90% of the health workers were able to use syndromic management of STDs appropriately, as well as treat opportunistic infections in HIV/AIDS; and 60 % of health workers were able to assess, diagnose and treat sick children appropriately.

IMCI Training. Over 88% (472 out of 549) of health workers from the demonstration districts were successfully followed up 4 to 6 weeks following training in Integrated Management of Childhood Illness (IMCI) to consolidate skills, and were given on-the-job training. At the end of the year 2000, all demonstration districts had adopted the IMCI approach, resulting in a cumulative total of 549 health workers trained in improved skills to manage common childhood illnesses. The cumulative figure represents 63% of the health facilities in demonstration districts with IMCI-trained health workers.

ZIHP, together with WHO, provided support to the CBOH to successfully host an IMCI inter-country operational research meeting. The main objectives were to review and share experiences of IMCI implementation from among the thirteen African countries represented at this meeting. Conclusions of the meeting were that training health workers alone without follow up and sustained supervision is not enough to bring about positive change in daily practice. Strengthening of the health system in general (for example, ensuring that basic drugs are available) is necessary for health workers to perform well.

[12] ZIHP Annual Report 2000 Final draft

Improving supervisory systems. A ZIHP consultant assisted the General Nursing Council to develop a monitoring and evaluation system for nursing quality assurance. Monitoring and evaluation (M&E) tools have been developed and pre-tested. To enhance M&E outreach activities, ZIHP purchased a vehicle for the Council.

With GNC's assistance, the Nurses and Midwives' Professional Code of Conduct has been disseminated to 1000 nurses and midwives, and a strategy for dissemination to all districts has been developed.

Conclusions and Recommendations

Overall, ZIHP has helped strengthen the technical and management capacity structures at the community, rural health centers and DHMT levels. This has been done through training and production of relevant technical materials, including guidelines and supervisory tools.

ZIHP has significantly contributed towards the improvement of the General Nursing Council supervisory functions through facilitation of its Strategic Plan, development of a Monitoring and Evaluation tool, and dissemination of the Nurses and Midwives' Professional Code of Conduct.

There is evidence to show that health worker performance has significantly been improved through the training facilitated by ZIHP. Training has included Integrated Management of Childhood Illnesses (IMCI), Integrated Reproductive Health (IRH), Integrated Competency-based Training (ITC), Employer Based Distributors (EBDs), and Community Based Agents (Community Health Workers, Neighborhood Health Committees, etc.). Health workers in ZIHP demonstration districts perform better than those in non-ZIHP demonstration districts in terms of management of common illnesses; NHCs are able to produce quality Action Plans; and Community Health Workers are able to do growth monitoring.

However, ZIHP support is mainly training and capacity building and not providing equipment (e.g., microscopes), supplies (e.g., drugs, needles, syringes), and logistics (e.g., radios, transport in form of motorcycles, bicycles or vehicles). This means health workers are trained adequately but lack the necessary equipment, transport, and drugs and supplies. For example, NHC members are trained and are able to come up with good Action Plans but lack the necessary funds to implement them, since the funding from the districts is highly inadequate.

Follow-up and supportive supervision of trained staff are inadequate. A number of cadres trained have not been followed up and are not supervised. A critical assumption underlying training is that the DHMTs will carry out supervision of trained health workers. ZIHP has helped build supervisory capacity by encouraging districts to nominate supervisors amongst the health workers for specific training programs. This ensures that these local supervisors follow up the health workers during routine supervision. ZIHP intends to assist the districts more through orientation of DHMT supervisors in supervisory skills as well as to supplement funding to some DHMTs for supervisory activities. The current plan by ZIHP to strengthen the supervisory capacity of DHMTs should be commended.

- **Recommendation:** To have positive short-term and long-term impacts, the training needs should be well integrated with services. There is need to have a more comprehensive program that encompasses training, follow-up supervision and provision of equipment, supplies and logistics and support for an improved referral system through provisions of means of transport and communication systems. To help ensure program impact, continuity and sustainability, overall program resource needs must be met. The GRZ, USAID and ZIHP should assess the reasons that needed backup support (drugs,

basic equipment, transport, etc.) are not available, and should provide supplemental resources from among available options.

ZIHP implementation of training activities is sometimes done at too short a notice. There are also questions about the cost-effectiveness of the practice where ZIHP staff comes from Lusaka and other distant places to train workers in Eastern Province, instead of using the trainers already present in the Province.

- **Recommendation:** ZIHP should consider decentralizing its training to the Provincial and/or District Offices, as this is expected to be more efficient, more effective, and more sustainable.

The DHMTs do not receive information on the cost of ZIHP-funded training, making it difficult for DHMTs to plan and budget for similar training.

- **Recommendation:** ZIHP should be more transparent in the implementation of its training activities, and provide all necessary financial information to the Provincial Health Office and the District Health Office.

4.1.1.5 IR5: Improved policies, planning and support systems for PHN interventions

Policy Development

Introduction

Both the Ministry of Health and the Central Board of Health still have a significant policy agenda, with a number of key policies yet to be developed. At the moment, MOH/CBOH policy development operates on an *ad hoc* basis, and is less efficient than it should be. However, ZIHP activities have contributed to improved management of the policy cycle, and have facilitated the development, approval and implementation of key policies.

Key findings

Since 1999, ZIHP has contributed towards the development of all health policies in Zambia, including the following key examples:

- National Health Strategic Plan 2000–2005 (draft)
- School Health Policy (draft)
- Reproductive Health Policy (draft)
- Hospital Policy (final draft)
- Health Care Financing Policy (draft)
- Health Education and Training Policy (draft)
- Nutrition Policy
- Mental Health Policy
- Oral Health Policy
- Quality Improvement Policy
- Child Health Policy

While the MOH has overall responsibility for health policy development, the initial inadequate staffing of the MOH with qualified, policy-focused professionals meant that the MOH typically was not represented on the policy working groups that initiated policy development. This

brought about a situation where key policy and related implementation issues were not given sufficient thought, and stakeholder participation was limited.

Thus, ZIHP's policy activities initially focused on strengthening the link between the MOH and the policy working groups – thereby reducing fragmentation and improving overall policy development. To accomplish this, ZIHP provided technical assistance to the Policy and Planning Directorate of the MOH, through both on-the-job training and a policy workshop for 25 managers and specialists from among the MOH, CBOH and six policy working groups. This capacity building for policy development has been a major cornerstone of ZIHP's work in the policy area, especially with respect to the working groups. The capacity-building approach included (1) identifying the appropriate steps in the policy development process, (2) providing relevant methodology and tools, and (3) identifying information and data sources for situation analyses and other aspects of policy development.

ZIHP has made a significant difference thus far in increasing the level of policy development skills in the health sector. However, since capacity building is still critical to improving the capacity and sustainability of policy development in both the MOH and CBOH, the ZIHP Policy Advisor will continue to work full-time to help accomplish needed strengthening.[13] Besides the advisor's personal involvement on a day-to-day basis, future policy workshops are scheduled later in 2001 and again in 2002.

The ZIHP Health Policy Advisor also provided critical technical assistance for the International Conference on AIDS and STDs in Africa (ICASA) in 2000 before, during and after the conference. This assistance made a difference in the planning and implementation of the conference, to the credit of the GRZ.

Conclusions and Recommendations

Despite ZIHP's considerable policy development capacity building and technical assistance (primarily to the MOH), ZIHP's assistance to the CBOH has not yet met the need for policy skills and competencies in policy working groups. Unfortunately, the Policy Directorate in the CBOH is still vacant, adding to the need for additional ZIHP support. In addition, ZIHP's policy staff in the MOH has not been sufficient to meet the increasing need for rapid and rational health policy development

- **Recommendation:** ZIHP's policy assistance should be more comprehensive and should be supportive of the entire NHSP, and all levels of the system. The MOH/CBOH and ZIHP should reassess the highest-priority areas for policy assistance, and together refocus ZIHP assistance to meet these priorities. The ZIHP Health Policy Advisor (or perhaps two advisors) should assume a leading role in training and building capacity within the respective policy units. The Advisor(s) should also strengthen policy skills and competencies among the policy working groups. This in turn should streamline the development of policies, and may reduce the number of drafts – and the amount of time – required to achieve the final product. Acknowledging the current policy workload in both the MOH and the CBOH, ZIHP should consider providing another full-time policy advisor so that one can support each policy unit – both in providing technical assistance and in helping to build capacity.[14] In addition, the MOH and CBOH should fill their vacant policy unit positions as quickly as possible.

[13] Note that the initial ZIHP policy, planning and systems support program did not envision a full-time advisor to the MOH, but because of the importance of policy development to the health sector (and the success of the ZIHP Program), ZIHP has willingly provided this technical assistance.

[14] Adding this full-time position will likely require a trade-off elsewhere in the ZIHPSYS or another ZIHP Program component.

ZIHP can also provide assistance at the different policy implementation levels. For example, some policies developed at district level have originated from different organizations, and they typically don't correspond to those developed at the MOH/CBOH level. This means that they must obtain MOH/CBOH approval, which is a time-consuming and unnecessary step if the district-level policies had been derived from the corresponding central-level policy documents.

- **Recommendation:** National-level policies should be developed in such a way that there is a companion policy suitable for adoption and implementation at provincial and/or district levels, as appropriate.

Planning and Support Systems

Introduction

ZIHP has contributed significantly to the development of planning guidelines for both District Health Management Teams and health centers and communities. ZIHP has also helped develop planning handbooks for 1st, 2nd and 3rd level hospitals. Since districts and hospitals need to have annual action plans approved and implemented before release of funds from MOH/CBOH, these planning guidelines and handbooks have filled a critical gap in streamlining that process.

One related GRZ system that is critical to all planning activities is the Health Management Information System (HMIS). The CBOH has had an operating HMIS since 1996, and ZIHP currently provides technical assistance to expand and upgrade the system to meet increasing needs. The design of the HMIS has taken into account the principle of decentralization, which ensures that districts are empowered to (1) manage and analyze their own information, (2) develop realistic action plans that respond to local needs on the basis of the data collected (evidence-based decision-making), and (3) carry out their own performance assessment. The assessment provides both quantitative and qualitative data which together allow the district to determine its level of achievement (based on established indicators) during the performance period being assessed. Thus, the HMIS in CBOH is continually improving the efficiency and effectiveness of data collection, analysis and utilization at all levels, in part by replacing multiple reporting channels with a single, more reliable channel. Once the HMIS information cycle is complete, the planning process can begin again, using the self-assessment outcomes (among other information) as inputs into activity planning.

Within ZIHP, the responsibility for HMIS falls under the Quality Improvement component of ZIHPSYS. The HMIS work supported by ZIHP helps to strengthen CBOH managers' skills and improve data collection, analysis and use at all levels through strong feedback mechanisms. The ZIHP HMIS Officer works in close collaboration with officers in the CBOH. The inputs, process and outcomes of this activity are jointly shared. However, this close integration of activities has made it difficult to measure specific ZIHP input and outputs.

Conclusions and Recommendations

ZIHP technical assistance has strengthened several key aspects of the planning process. These include:

- Resource-based rather than need-based planning
- Decentralization of authority to districts for priority-setting in their own action plans
- Simplification of the planning process, with a focus on priority programs
- Planning process well articulated at all levels:

NHCs → H/C → DHMTs →PHO → CBOH/MOH

However, the GRZ at all health levels receives no information on the financial resources used to achieve these excellent, positive results. Most ZIHP activities in various districts are directly funded by ZIHP, and as a result all the districts visited did not seem to know the total expenditure. As such, the districts have inadequate information for planning and budgeting similar activities, and cannot assess their potential sustainability once ZIHP has ended.

- **Recommendation:** Preferably, the flow of funds to ZIHP-supported activities within districts should be through the DHMTs. Where this is not possible, ZIHP needs to quantify its resources for technical support. Thus far this information has not been provided to DHMTs even after the interventions and activities have been carried out.

ZIHP has invested considerable effort and resources (not quantifiable) in the development, expansion and implementation of existing systems without adequate follow-up. These systems include:

- Quality Assurance
- Performance Audit
- Hospital Accreditation
- HMIS and FAMS
- Planning

- **Recommendation:** ZIHP should provide follow-up and supportive supervision in order to sustain interventions such as quality assurance and accreditation. ZIHP should also consider providing resources to continue the accreditation program.

Most ZIHP capacity-building activities in districts are not fully funded. The co-financing creates a problem in the sense that if districts do not have enough funds then these activities cannot be implemented, or if implemented they are not sustainable.

- **Recommendation:** To help ensure program impact, continuity and sustainability, overall program resource needs must be met. The GRZ, USAID and ZIHP should assess the reasons that needed backup support (drugs, basic equipment, transport, etc.) are not available, and should provide supplemental resources from among available options.

All the districts visited indicated that they were experiencing delays in the availability of funds for ZIHP-supported activities. In one instance, activities which were to be carried out in the first quarter ended up being implemented in the fourth quarter. This situation created pressure for districts, and often interfered with completing action plan activities on time.

- **Recommendation:** Release of funds to ZIHP-supported activities should be timely so as to avoid implementation pressure arising from most of DHMT activities being implemented in the last quarter. Early release of funds can be a source of motivation to CBDs.

There has been a tremendous response from NHCs in supporting community-based health activities such as the selling of ITNs. Community Health Workers seemed to understand their roles. However, the incentive behind the commitment appeared to be the profit rather than their own contribution to better community health.

- **Recommendation:** ZIHP should explore ways and means of coming up with other incentives for CHWs in addition to sharing profits from social marketing product sales.

HMIS data are generally captured from the demonstration districts through follow-ups and supportive supervision. As noted above, the HMIS system is becoming increasingly more effective. However, the reliability of these field data should be verified on a sample basis.

- **Recommendation:** ZIHP should explore ways and means to come up with measures -- including strengthening the supportive supervision system -- that will ensure that the data collected are both reliable and accurate.

4.1.2 Assessment of the Four Technical Areas

The team found this assessment of the four technical areas provided a wealth of information about the ZIHP Program, principally from an implementation focus. On the other hand, while there are obvious interrelationships among these four areas, they have been difficult to present fully in that light. The linkages are there, but perhaps not so obvious as the reader would like – since to appreciate them fully one should have had the benefit of the field trip.

4.1.2.1 HIV/AIDS

Introduction

Zambia's health services face the challenge of responding to the HIV/AIDS epidemic. The national HIV sero-prevalence is 19.7%. There is an increased burden of care at all levels of the health system and in communities as the number of those seriously affected by AIDS and the number of dependent orphans increases. Sero-surveillance studies show a decline in prevalence in urban women aged 15-29 with a tendency to decline in rural women aged 15-24. This trend is correlated with educational level. While prevalence is declining in educated young women, it is stable or rising in those with low education. Deaths, sickness and absenteeism resulting from AIDS are one element of the serious attrition in the health system, and are affecting household food resources in some communities

The challenge for ZIHP as an integrated health program is how to respond to this disease, which has typically been addressed through separate vertical programs, often through the NGO sector.

Key Findings

The National HIV/AIDS strategic framework 2000-2002 provides a guideline as to how ZIHP's comparative advantages can best be deployed. ZIHP strategies fit within this framework in terms of ZIHP's focus on behavior change, education, and condom social marketing programs aimed at youth. ZIHP is also working with NGOs, workplaces, health providers and community members to address prevention and care issues.

ZIHP's structure of four collaborating agencies working in the framework of the existing Intermediate Results compounds the problem of how to respond to the HIV/AIDS epidemic in an integrated approach. Each ZIHP agency is working on certain aspects of HIV/AIDS, and the place of HIV/AIDS in an integrated response is being strengthened, but this process of technical integration is still under way. This was evident in the meeting of the Assessment Team with the HIV/AIDS technical working group, where ZIHP's response to HIV/AIDS was expressed as the separate activities of each agency, rather than an integrated approach that is being implemented through different mechanisms.

ZIHP has carried out a range of activities in HIV/AIDS in various roles, including acting as a source of technical advice, capacity building, training, and direct implementation of behavior change interventions, as follows:

- Behavior change and social marketing interventions with national coverage, primarily targeting youth with multiple intensive messages on safer sex, both abstinence and condom use
- Support for institutionalising youth organizations working in HIV/AIDS communication
- Collaborating in the development of HIV/AIDS policies and frameworks at different levels, including input to the drafting of the National HIV/AIDS strategic framework, and working with the General Nursing Council and the Zambia Nurses Association to support their strategic planning process.
- Training health providers and community members in HIV/AIDS. 171 persons were trained in HIV/AIDS by ZIHPSERV in 1999-2000. A curriculum for training traditional healers in HIV/AIDS has been developed.
- Strengthening the private sector response through the FACEAIDS and EBD programs
- Funding and capacity-building for NGOs working on HIV/AIDS and funding and training for two Technical Support Organizations
- Technical input and assistance in key meetings and conferences that focus attention on HIV/AIDS
- Collaborating and providing substantial contributions to USAID partners in other HIV/AIDS projects. Key examples are collaboration with the International HIV/AIDS Alliance and SFH on training for health workers in VCT; work with World Vision International on the cross-border project for high-risk groups; and work on the Ndola MTCT demonstration project to enhance community mobilization and male involvement.

These activities have been characterized by their high technical quality, which was recognized by the different organizations interviewed by the team. However, many of ZIHP's activities have operated at the national level. Integrating HIV/AIDS into district and community-level activities has been more problematic. ZIHP is using several approaches to move towards integration of HIV/AIDS into district and community activities: (1) the design of the NGO grants program, which requires close interaction between selected NGOs and the DHMTs; (2) an integrated package of training for different community agents that includes HIV/AIDS; (3) including NGO and health clinic staff from the same district in the same training activities. However, there are still issues around the extent of community involvement, as discussed below.

Conclusions and Recommendations

Among other HIV/AIDS activities, the ZIHP program is providing a substantial contribution within the National Strategic Framework on AIDS to addressing behavior change issues for youth through its mass-media youth campaigns and youth-focused activities. However, there is a need to strengthen interventions to reach less educated and deprived youth.

- **Recommendation:** ZIHP's communication program should continue to support youth mass media campaigns aimed at urban and peri-urban youth, but should increase support for interventions to reach youth in rural areas, and out-of-school youth. ZIHP could explore using the NHC radio distance education model to create a supportive course for youth peer educators in collaboration with local radio stations.

ZIHP also promotes improved HIV/AIDS prevention and care in the community through training community peer educators and health staff to promote AIDS prevention and care in the community. However, ZIHP's community-level support is mainly through the NGO grants program that supports NGOs working in HIV/AIDS.

There is a need to increase community involvement and empowerment to deal with HIV/AIDS. Despite the fact that communities defined HIV/AIDS as a priority area in 85% of

their action plans, HIV/AIDS is not a major focus of the NHC community activities. Based on meetings with at least ten NHCs, the Assessment Team's perception of community priorities are that environmental health was a major concern, followed by issues of maternal and child health and malaria. With one exception, HIV/AIDS and STIs were not mentioned spontaneously by any NHC members or health providers interviewed, except those working in NGOs focusing on HIV/AIDS. Improved case management for STIs has not been a major focus of ZIHP training, and was also not perceived as being a priority at the local level.

- **Recommendation:** Future ZIHP workplans should ensure that all workshops and all training programs for CBAs will devote significant time to HIV/AIDS, and that NHCs will have the opportunity to consider options for HIV/AIDS activities in developing their action plans. ZIHP should also give priority to training providers in the syndromic management of STIs, and in training CHWs in promoting early recognition and treatment of STIs. These activities should be developed in collaboration with the national HIV/AIDS Technical Working Group on Sexually Transmitted Diseases.

ZIHP could consider collaborating with the International HIV/AIDS Alliance to strengthen the community response to AIDS, by using the Alliance's participatory methodology to identify needed prevention and care activities at community level and the potential roles of community organizations, which could then be fed back into ZIHP training modules. Two examples of community approaches in neighboring countries provide an idea of the potential scope: (1) in one area in Tanzania, community organizations were led through a mapping exercise that identified situations that encouraged high-risk behavior and proposed ways to reduce risk; and (2) communities in Zimbabwe have set aside communal land to help support affected families.

ZIHP is supporting several NGOs whose programs could provide models for scaling up in other areas. For example, Thandizani and Moomba, two church-based NGOs/CBOs, are effectively providing VCT services and care and support at the community level. Also, SCAN is working with street-kids.

- **Recommendation:** The Assessment Team supports ZIHP's plans to document the Thandizani model in a case study. ZIHP could also work with other NGOs to document replicable experiences and better practices and support them in networking with similar organizations to identify common challenges and successful approaches.

The FACEAIDS program is a well-designed, introductory package to promote demand for HIV/AIDS services by companies. Experience from other countries shows, however, that workplace programs need some form of ongoing support. For example, the Bank of Zambia representative stated: "when we need ZIHP, they are there." Transition mechanisms need to be introduced to move ZIHP away from this implementation role.

- **Recommendation:** The Assessment Team understands that ZIHP recognizes the need to ensure the sustainability of FACEAIDS and has already identified an NGO to manage the program. We encourage ZIHP to identify additional Zambian NGOs as needed, with experience of workplace programs, who can provide this ongoing support.

There are still few PLWA groups outside the main urban areas.

- **Recommendation:** Strengthen networking for existing PLWA groups with NGOs working on HIV/AIDS prevention and care at the local level, and in particular link local NGOs with the ZIHP+ program on legal rights for PLWAs. CHEP and PLWA projects visited were unaware of this project.

Much of USAID's HIV/AIDS program is outside ZIHP (such as the SCOPE Project) or is carried out primarily by other partners, with input from ZIHP. For example, ZIHP works with World Vision on the border project. ZIHP has also been a successful partner in developing community mobilization and male involvement strategies for the Ndola Demonstration Project.

- **Recommendation:** ZIHP should continue to link closely with these other research and community-level projects, in particular those addressing VCT, care and support. ZIHP should also ensure that lessons learned about both implementation and research are fed back into ZIHP's training program; for example, incorporating the experiences in promoting male involvement and community mobilization around MTCT into community training modules.

A lot of resources have gone into technical support through training workshops. However, expanding outreach by NGOs (such as Thandizani in Lundazi District) has been limited by several factors, including transport.

- **Recommendation:** More CHWs and TBAs need to be trained to make follow-up of AIDS cases easier. To help ensure program impact, continuity and sustainability, overall program resource needs must be met. The GRZ, USAID and ZIHP should assess the reasons that needed backup support (drugs, basic equipment, transport, etc.) are not available, and should provide supplemental resources from among available options.

4.1.2.2 Integrated reproductive health

Introduction

The objective of the ZIHP integrated reproductive health (IRH) program is to provide the promotive, preventive and curative interventions required to ensure the reproductive health of men, women and adolescents. The integrated package is comprised of family planning, safe motherhood, post-abortion care, emergency contraception, promotion of breastfeeding, prevention and treatment of STIs, intermittent presumptive treatment for malaria in pregnancy, and prevention of HIV/AIDS, including mother to child transmission.

A national-level technical working group, chaired by the Chief of Party of ZIHPCOMM, has been formed for the purpose of planning and coordinating IRH activities within Zambia. The working group, which meets monthly, includes representatives from the various components of ZIHP and some ZIHP+ projects, and also includes representation from the MOH and CBOH. However, it is difficult for the CBOH to maintain a presence at these meetings since there is only one reproductive health advisor who is often too busy to attend.

Key Findings

There are a tremendous number of activities being undertaken in integrated reproductive health through the four components of the ZIHP Program, as well as through some of the field-supported projects. They include but are not limited to the following:

Government systems support: (1) Support to the government to finalize the integrated reproductive health policy and action plan (ZIHP continues to support the development of the action plan, which has been in draft since 1997, in the hopes that it will be finalized and approved in the near future); (2) dissemination of quality standards for IRH and support for application of these standards as part of supervision; (3) help to provinces and districts in use of health information for district action planning and supervision; (4) support to University

Teaching Hospital to strengthen the post-abortion care (PAC) curriculum; and (5) launch of white ribbon campaign.

Communications: (1) Effective mass media and grass roots efforts to promote safe motherhood and family planning; (2) assistance to the MTCT working group in drafting a communications strategy and implementation plan; (3) dissemination of family planning materials such as the family planning counseling kits (and training video) for facility-based providers; (4) education of NHC members about IRH through a distance education program; (5) painting the FP logo on health center walls, indicating the package of RH services available at the clinic; and (6) production of a birth planning card.

Training: (1) Assisting districts to train health workers to deliver IRH services and community-based agents to counsel on safe motherhood, family planning counseling and distribution of contraceptive supplies; (2) training agents to distribute socially marketed RH commodities (260 TBAs, 185 CBDs, 89 EBDs); (3) developing training plans for traditional healers in IRH and referral; and (4) training 817 breastfeeding promotion volunteers and creating related support groups.

Other: (1) Assisting districts through community NGOs to promote safe delivery practices, community level transportation schemes for obstetric emergencies and distribution of contraceptive supplies; (2) supporting districts in distributing information and supplies through workplace and private providers; and (3) providing IRH information and counseling to men and boys through football (training camps and mass media).

Conclusions and Recommendations

ZIHP has helped Zambian demonstration districts to make an impressive move towards integrating reproductive health activities.

- **Recommendation:** Continue to support the CBOH to finalize the policies, guidelines, and plan of action to move forward with the integration of services. Consider small operations research projects to document lessons learned and better practices related to integration of services.

ZIHP is contributing to an increase in the contraceptive prevalence rate in Zambia; however, the fertility rate remains high and contraceptive prevalence rate remains low. While integrating services sometimes offers more opportunities for reaching clients with family planning education and services, FP activities are frequently becoming sidelined within ZIHP activities where many other important health services are being offered. For example, during field visits, NHCs talked about many activities spontaneously but needed to be prompted to talk about FP.

- **Recommendation:** Within the reproductive health portfolio (and especially during training of health workers), try to emphasize family planning and its positive effect on other health issues such as child health, maternal health, etc.

Contraceptive uptake is low in some areas due to fears of side effects.

- **Recommendation:** Concentrate on dispelling myths about side effects of family planning methods through delivery of education messages/materials (ZIHPSOM and ZIHPCOMM) and through appropriate training of providers in counseling about side-effects.

Although Depo-Provera has been approved for use in a demonstration district in the Copperbelt Province (under Pop Council/CARE activities) it is currently not legal for national

distribution in Zambia. This obviously limits the choice of contraceptives available to women (an element of quality of care). Once legalized, Depo-Provera is likely to be a very popular option as it has been in many other African countries.

- **Recommendation:** Work with the CBOH to lobby for the prompt legalization of Depo-Provera within Zambia.

There are several areas where socially marketed IRH products could be promoted through the private sector.

- **Recommendation:** Promote socially marketed IRH products through FACEAIDS, traditional healers, private practitioners, etc.

According to current Zambian law, Environmental Health Technicians (EHTs) are supposed to be providing promotive and preventive health care services only. However, through ICT training they are being taught limited curative health interventions, and because they are often the only providers in their health centers, they often end up providing such services.

- **Recommendation:** Help the government to revise legislation and/or regulations so that EHTs registered with the Medical Council of Zambia can legally provide curative services appropriate to their training.

Many cadres of health workers are being trained but they complain that when they return to their posts, they are unable to practice what they have learned due to various reasons such as lack of equipment, supplies or finances to implement.

- **Recommendation:** To help ensure program impact, continuity and sustainability, overall program resource needs must be met. The GRZ, USAID and ZIHP should assess the reasons that needed backup support (drugs, basic equipment, transport, etc.) are not available, and should provide supplemental resources from among available options.

TBA training has caused great demand in the districts for further TBA training.

- **Recommendation:** Although data in Zambia show that training of TBAs has not impacted on the maternal mortality rate, ZIHP nonetheless is under pressure to scale up TBA training. ZIHP should advocate to partners to collaborate on alternative programs to reduce the maternal mortality rate.

4.1.2.3 Child Health and Nutrition

Introduction

With under-5 mortality rates at 200/1000, infant mortality rates exceeding 100/1000 and maternal mortality above 625/100,000, further improvement of child health and nutrition interventions are of critical priority to the overall measurement of ZIHP effectiveness and impact. Key maternal and health interventions include (1) the provision of the integrated promotive and prevention package (treatment, reduction of case fatality and prevention of malaria); (2) reduction of under-5 Vitamin A deficiency and enhanced nutritional stature; (3) diarrheal disease prevention; (4) IMCI; (5) increased immunization rates; (6) breast feeding; (7) family planning; and (8) reduction of STIs and MTCT of HIV/AIDS.

Key Findings

ZIHP's areas of focus in child health include:

- Development of guidelines, training and supervision of IMCI initiatives and reduction of MTCT;
- Orientation, participation and implementation of Child Health Week;
- IEC mass media programs, distance education, "The Better Health Campaign" and related program on IRH and HIV/AIDS;
- Community PLA and NHC development and communications activities to include community/DHMT support and strengthening of routine EPI initiatives, diarrheal disease control (potable water, sanitation and Clorin), growth monitoring, malaria control, ARI, related reproductive health issues and strengthening of nutrition activities, particularly growth monitoring and anemia reduction.

Conclusions and Recommendations

Child Health Week. ZIHP has played an important role in planning, developing and implementing Child Health Week in demonstration districts and provinces, particularly in the areas of:

- Planning orientation meetings for health center and related communities;
- Supporting key management, administrative and supervision activities;
- Providing key financial support for project implementation (KW120 million in 2000) to include materials, equipment, supplies and transport;
- Providing technical assistance related to the provision of child health services;
- Supporting supervision of provincial and district activities by the MOH and the National Food and Nutrition Commission; and
- Assisting with evaluating and determining the impact of national, provincial and district activities.

- **Recommendation:** ZIHP should continue to play a major role in the planning and supporting Child Health Week activities. National, provincial and district officials have indicated that in addition to continuing this role, ZIHP should consider expanding the Child Health Week mode of highly collaborative planning, operation and resource support to ongoing child health services within the demonstration districts throughout the remainder of the year.

Development of IMCI guidelines, training and supervision. Major improvements have occurred in IMCI guidelines, training and supervision initiatives at the DHMT and community levels. DHMT and community health workers interviewed by the Assessment Team believe that their preventive and diagnostic capabilities have been improved significantly through ZIHP-supported training. Trained individuals indicated that at least one follow-up consultation had been achieved by ZIHP or DHMT supervisors during the past year. ZIHP-trained community and clinical health workers indicated that additional supportive supervision was needed to ensure ongoing improvements in technical capacity development. These improvements are critical in order to deal with the scope and scale of child health and nutrition problems that the health workers encounter.

- **Recommendation:** ZIHP program activities should make every effort to ensure that increased supportive supervisory visits occur with trained personnel to assure appropriate in-service training support. Supervisors should review clinical and CHW client records; discuss difficult diagnosis, care, prevention and referral cases; and provide appropriate guidance to staff and volunteers.

ZIHP-trained personnel and DHMT officials indicated some concern with the protocols recommended by the ZIHP-sponsored training regarding presumptive treatment for malaria for every fever. Clinical officers indicated that many of the presenting fevers needed

additional diagnostic considerations, and that over-prescription of malarial drugs might hasten resistance.

- **Recommendation:** ZIHP should review the training curriculum and diagnostic/treatment protocols regarding presumptive treatment for fever, and should consider the benefits and risks of maintaining the current protocols for specific locations within the provinces and district demonstration areas.

ZIHP-trained personnel and DHMT officials indicated that considerable increases in drugs, equipment, transport and communications equipment were necessary to insure that the appropriate conditions existed to fully utilize their IMCI training.

- **Recommendation:** To help ensure program impact, continuity and sustainability, overall program resource needs must be met. The GRZ, USAID and ZIHP should assess the reasons that needed backup support (drugs, basic equipment, transport, etc.) are not available, and should provide supplemental resources from among available options.

ZIHP has provided excellent monitoring and evaluation formats for following the progress of CHWs and for providing health-related services for clients and target populations. However, the level of ZHIP resource investments in IMCI are not readily understood by CBOH, PHMT and DHMT officials. Without this understanding of overall resource investments, the GRZ officials do not fully appreciate the cost-effectiveness, cost-efficiency, and sustainability of various IMCI program approaches and interventions.

- **Recommendation:** ZIHP should provide appropriate financial information related to various IMCI interventions, and should underscore the economic rationale for the IMCI model of care.

IEC mass media programs in support of Child Health and Nutrition. ZIHP has produced a useful array of IEC materials to support ongoing child health and nutrition interventions and Child Health Week. These include posters, print, radio, interpersonal communications materials, laminated cards for CHWs, distance education materials, dramas, the Better Health Campaign, and related programs on IRH, malaria and HIV/AIDS.

ZIHP materials in support of child health which were available in the clinics and in community locations, while of high quality, were generally in English, and were generally in short supply or unavailable.

- **Recommendation:** ZIHP child health IEC programs and materials should be made more readily available for all CHW and clinic facilities in the demonstration districts and, where appropriate, translated into the local written languages.

Promoting PLA and NHC development activities. ZIHP has been very effective in promoting child health and nutrition PLA and NHC planning and implementation activities in coordination with the DHMTs. These activities have generally included support to both communities and DHMTs in strengthening EPI initiatives, diarrheal disease control (Clorin, ORS, potable water and sanitation), growth monitoring, malaria control, ARI, related reproductive health issues and strengthening of nutrition activities, particularly growth monitoring and anemia reduction. Training of staff, HMIS formats, supervision and local planning efforts appear to be well organized throughout the demonstration districts.

In almost all communities visited, there was a general lack of basic drugs, physical facilities, equipment, transportation and communications to deal with the multiple problems identified by the communities in child health and nutrition, and in the related areas of HIV/AIDS, IRH and malaria.

- **Recommendation:** To help ensure program impact, continuity and sustainability, overall program resource needs must be met. The GRZ, USAID and ZIHP should assess the reasons that needed backup support (drugs, basic equipment, transport, etc.) are not available, and should provide supplemental resources from among available options.

Social marketing efforts (especially for Clorin and ITNs) were highly visible and apparently effective interventions which were enthusiastically supported by NHCs. However, the enthusiasm for these "physical" interventions appeared to diminish community interest in other related diarrheal disease and malaria initiatives.

- **Recommendation:** ZIHP should continue to vigorously support the social marketing initiatives but should also develop similar high-impact strategies for other key diarrheal disease and malaria interventions through renewed IEC and supervisory emphasis.

4.1.2.4 Malaria

Introduction

In principle, ZIHP's malaria strategy directly supports the National Program. The National Malaria Strategic Plan has eleven components or areas of focus:

- Insecticide Treated Nets
- Targeted Vector Control
- Epidemic Preparedness
- Information, Education and Communication
- Clinical Management and prophylaxis or intermittent treatment in pregnancy
- Drug procurement and distribution
- Laboratory diagnosis
- Malaria and Nutrition
- Monitoring and Evaluation
- Research
- Human resources and capacity building.

Key Findings

ZIHP has significantly contributed to the National Malaria Control Program mainly in the following areas:

- **Improved case management** at the health center and community levels through production of treatment guidelines.
- **Malaria Prevention** through promotion of Insecticide Treated Nets (ITNs) and Information, Education and Communication (IEC).
- **The ITN program** is a joint venture between ZIHP and JICA. ZIHP provides training, IEC materials, social marketing of ITNs and re-treatment chemicals, while JICA provides microscopes, transport, and anti-malarial drugs. Nets are sold for K10,000.00 each. 90-95% of sales is through clinics and sales agents, with only a small proportion (5-10%) through retailers. Promotion is done through drama, school-based programs, anti-malaria clubs, radio programs, peer educators, and an annual Miss PowerNet contest. Re-treatment rates are as low as 10%, possibly due to inadequate community sensitization, affordability, and at times inadequate supply of the re-treatment packets. However, at Jalama NHC in Mwase-Lundazi, the

assessment team was told that each net sold includes a re-treatment calendar showing when the re-treatment is due. This arrangement is supposed to assist in making sure nets are re-treated at the appropriate time. Net re-treatment could be improved through a variety of mechanisms, including use of "change agents" (influential community members), more effective promotion messages, and perhaps even entrepreneurial community members (or sales agents) who establish a local re-treatment service.

- **Support for Drug Policy change.** ZIHP was part of a group of technical experts who reviewed the current drug policy and recommended a change in the first-line drug from Chloroquine to Sulphadoxine/Pyramethamine (SP or Fansidar).
- **IMCI training** at Health Center level, which includes malaria.
- **Training of CHWs and NHCs in malaria control.** This training focuses mainly on case management and ITNs. Sales agents are trained in ITN use, treatment of nets, etc., and monitoring the sale and usage of ITNs.
- ZIHP contributed significantly towards the development of **the National Malaria Strategic Plan**.
- **Better Health Campaign.** Malaria has been one of the main areas of focus in the Better Health Campaign sponsored and facilitated by ZIHP. This has been perhaps the most successful health campaign ever launched in Zambia in terms of the quality of its messages. Both MOH and CBOH acknowledge its excellent quality and contribution to the National Health Service.
- ZIHP implements the **Integrated Malaria Initiative (IMI)** originally started by the USAID-funded BASICS Project in four districts: Kitwe, Chama, Lundazi and Chipata. This involves social marketing of ITNs/Insecticides, IEC, IMCI, and research (in collaboration with ARCH). The overall ZIHP malaria program is not confined to these four districts, nor to the twelve demonstration districts, but essentially reaches every corner of Zambia.

Conclusions and Recommendations

ZIHP has contributed to and works within the National Malaria Strategy which includes early recognition, care seeking, ITN promotion, appropriate case management at health facilities, and prophylaxis for pregnant women.

The collaborative efforts of ZIHPSOM and ZIHPCOMM have helped government to raise awareness about malaria prevention, build demand for PowerNet, and market supplies of ITNs both nationally and in the four IMI districts. In these districts 30% of households now own ITNs. Recently, ZIHP has launched a new brand of ITN, Safenite.

While ZIHP has done very well in the Social marketing of ITNs and has created demand for them, re-treatment rates are as low as 10% -- possibly due to inadequate community sensitization, affordability, and at times inadequate supply of the chemical (e.g., in Kagunda NHC). ZIHP has made the promotion of ITN re-treatment its top priority, and hopes that net re-treatment rates will improve.

- **Recommendation:** Net re-treatment could be improved through use of "change agents" (influential community members), more effective promotion messages, consistent monitoring, ensuring a steady supply of re-treatment chemical, and perhaps even through entrepreneurial community members (or sales agents) who establish a local re-treatment service. However, ZIHP feels the current re-treatment messages are effective; the challenge is to reach the hard-to-reach and scale up the campaign. ZIHP should do exactly that: continue to use the current messages on a larger scale and develop strategies for the messages to reach the remotest parts. Since the responsibility for distribution of ITNs is now going to shift to the DHMTs, the team recommends that ZIHP

continue to offer necessary logistical and technical support to the DHMTs until it is satisfied that the DHMTs can cope with this responsibility.

There is some evidence that malaria incidence has been reduced by 5% in Mwase-Lundazi RHC catchment area since the introduction of ITNs, but it is too early to see significant change in overall malaria morbidity and mortality.

Currently, ZIHP works in partnership with JICA in the malaria control strategy, the latter providing transport, equipment and drugs. ZIHP does not provide these items.

- **Recommendation:** ZIHP should continue to foster and strengthen complementary partnerships in the control of malaria.

Currently, ZIHP is not active in the promotion of other malaria control strategies like house spraying and environmental control. The malaria prevention messages are not comprehensive enough, but tend to focus on ITN promotion. ZIHP strongly feels they have no reason to include other messages because ITNs are the *best* prevention method available to and affordable by households in Zambia.

- **Recommendation:** The assessment team agrees with ZIHP's strategy to promote ITNs as the best prevention measure. However, the team does not think that the Zambian people should be given the picture that *no other* method of malaria prevention works and is affordable because that is not true. No single method will control malaria. ITNs only work when someone sleeps under them; we should note that there are a number of people exposed to infected female anopheline mosquito bites before they actually go to sleep. Hence messages on personal protection and messages that teach people about the biting habit of the gambiae complex anopheline mosquito are important. Targeted vector control is also effective for those who can afford it. We therefore recommend that ZIHP malaria IEC messages should continue to promote ITNs as the best malaria control method but should not discourage other complementary measures of malaria control. Other IEC messages should emphasize the benefits of using other methods as well.

4.1.3 ZIHP Contribution to GRZ Health Reform

Introduction

Health reform in Zambia is a sustained process of fundamental change in national policy and institutional arrangements. This process is guided by the Government and is designed to improve the functioning and performance of the health sector, and ultimately to improve the health status of the population. The vision is to provide Zambians with equity of access to cost-effective, quality health care as close to the family as possible. The cardinal goal of the reforms is to create environments conducive to better health and to empower individuals and the community to take care of their health problems.

Key findings

ZIHP recognizes and supports the complex and dynamic nature of the Zambian Health Reforms and seeks to address this in several ways:

- Improving the health status of Zambians through partnership with communities, government, NGOs and the private sector. This partnership based on the shared conviction that well integrated and well coordinated community-led interventions require the enabling environment of the National Strategic Health Plan;
- Supporting implementation of sustainable and cost-effective interventions; and

- Providing a conceptual and organizational framework – the Zambian Integrated Health Program – for implementing mutually agreed health interventions.

Conclusions and Recommendations

ZIHP has provided substantial support to the health reform process in systems development, capacity building, policy development, planning and budgeting, etc. Most of the people interviewed indicated that ZIHP, through USAID, is a major partner in realizing the objectives of the health reform vision. It was evident in the field that partnerships with the community to take care of their own health problems have been enhanced in program sites. In addition, private-sector participation in the provision of health services through social marketing and employer-based agents has begun to take shape. All these are major elements of the reform process.

Despite these positive contributions to health reform by ZIHP, during the Assessment Team's interviews and field visits a number of people representing GRZ institutions at central, provincial and district level perceived a structural problem between CBOH and ZIHP, which they feel has led to competition rather than complementarity. Even if activities appear to be integrated into one action plan, implementation is sometimes done in a parallel, or at least not fully coordinated, fashion. As just noted, the framework for providing support to the health sector is through the National Health Strategic Plan (NHSP), and support can be through a "financial basket" and/or an "activities basket." ZIHP's support contributes to the basket of activities, which have been prioritized within the NHSP at various levels of the health care system. The ZIHP Program comprises approximately half of USAID's annual financial contribution to the health sector. On the other hand, about 10% of USAID's annual contribution is from its Sector Program Assistance (SPA), and these funds flow directly into the financial basket.

Some of the same GRZ officials in the field also raised the issue of efficiency in implementation of activities. There was a feeling that if activities in ZIHP's four technical areas were well coordinated and implemented with CBOH activities at provincial and district levels, there are likely to be gains in both efficiency and effectiveness resulting from the synergistic effect. Decentralizing some ZIHP activities to provincial and possibly district levels was also widely mentioned. However, since provincial offices have only recently been established and staffed, their absorptive capacity may be limited initially. Provincial Offices and DHMTs indicated that sustainability could only be achieved by developing capacity at these levels and then decentralizing some of the activities currently being initiated centrally. Transparency was also identified as a concern, in the sense that ZHIP has not been providing information on the cost of its field programs. This has implications on future planning and sustainability at provincial and district levels, since the financial implications of program expansion are not clear.

- **Recommendation:** During the remaining implementation period of the ZIHP Program, ZIHP and the CBOH should emphasize achieving more complete integration in planning, budgeting and implementing activities, so that ZIHP more effectively complements the achievement of the strategic plan objectives. Integration is important for gains in both efficiency and effectiveness, and it can also strengthen partnership between CBOH and ZIHP.

4.1.4 Importance of Behavior Change

Introduction

Behavior change plays a central role in achieving USAID's strategic objective of "Increased use of integrated child, reproductive health and HIV/AIDS interventions." Behavior change interventions aim to create awareness, improve knowledge, foster positive attitudes, provide skills for action, and affect social norms through interventions targeted both at the individual and at social change in the community. The focus of messages is wide-ranging, including (1) individual and community responsibility for health through the adoption of preventive behaviors; (2) more informed health providers using a client-centered, holistic approach, (3) increased commitment of the private sector; (4) national awareness of and openness about problems and national leadership; and (5) reduction of stigma and discrimination.

The complexity, intensity, and approach of ZIHP's communication campaigns vary greatly. Some, such as Child Health Week, are primarily focused on creating demand for services around a straightforward issue: better health for children. Other issues like HIV/AIDS, STIs and FP are more complex and require deeper analysis of the underlying causes of behavior.

Key Findings

Behavior change in ZIHP's health areas of interest. As described in the section on IR1 (4.1.1.1), ZIHP's integrated health promotion approach affects behavior through changing attitudes to health, with the aim of achieving increased demand for services and products. Evidence from ZIHP reports and from team observations in districts visited suggests that this approach has in fact led to changes in attitudes and behaviors by individuals and social institutions, such as:

- Greater community understanding of the value of and adoption of specific health practices, in particular using mosquito nets to prevent malaria and using chlorinated water to prevent diarrhea; higher acceptance of family planning was also reported by ZIHP
- Greater attendance for child health services, particularly at growth monitoring posts
- Some anecdotal evidence of greater male involvement and male support [15]
- A new attitude to the role of the community members in proactively promoting good health through neighborhood health committees
- Greater acceptance by some managers at private-sector and community institutions of their role in promoting health through peer education
- The preconditions for improved health provider ability to support individual behavior change through, in particular, their initial favorable reaction to and use of the "profiling" approach to family planning clients.

One of the major strategies has been to empower communities through training NHC members. This training helped to create new awareness and a stronger set of community values around health issues. NHC members have been empowered to take on new assertive roles in promoting health issues – which is likely to facilitate involving the NHCs in promoting safer sex issues. It is interesting that the major behavioral result from NHC training has been in social roles: for example, in one community the NHC has been pushing the district council to clean up the environment.

The challenge is to document this process of change at the community level, to identify barriers and facilitators to change and methods of sustaining these new behaviors, in order to guide other Zambian districts in scaling up individual and community responsibility for health. In-depth description of this process in selected communities could include the mix of media and interpersonal approaches used, detailed costs for these interventions, and

[15] Reported by health staff and NHC members at the Ndola Health Project and one of the growth monitoring points visited.

background profiles of the types of people involved in NHCs (most of whom are men). One issue that might affect future sustainability, for example, were the comments to the team from one group of women NHC members that their earnings from socially marketed products, including nets, helped in getting male support. Yet nets are not a product with repeated sales: what will the incentive be once most community members have bought nets?

Behavior Change and Behavior Change Strategies for HIV/AIDS. The IR section also noted initial evidence that ZIHP's mass media interventions for behavior change in HIV, which were targeted at youth, have contributed to the adoption of safer sex behaviors at the individual level and to better health practices. ZIHP designed the campaigns using ongoing research studies to identify factors that place youth at risk, and facilitators and barriers to change. Safer sex campaigns have used a combination of approaches to provide information, raise awareness among youth, and role-model behavior. Messages promote both abstinence and, for sexually active youth, condom use. This approach has at times been daring, questioning current social norms about sexual behavior, particularly for women. The campaigns and supporting youth events and media materials are targeted both at the individual and intended to influence more open and supportive social norms among youth about safer sex.

At the community level, behavior change interventions on HIV/AIDS need to create awareness, foster a supportive climate for change through provide skills to youth, ensure condoms are available to sexually active youth, and combat stigma. Individual NGO programs such as Thandizani and Hope Humana have also had some success in changing community norms, particularly around issues of stigma and HIV, through a combination of VCT services, outreach programs, and building the self-esteem of PLWAs, though not enough is documented about the process of attitude change in these communities.

In some districts, such as Ndola, the DHMT's HIV/AIDS Committee has developed a coordinated HIV/AIDS strategy. In general, however, communication activities in the ZIHP districts have been sporadic and dependent on a strong push from individual NGOs and CBOs. Most interventions are also still focused on creating awareness and providing information. There is a need for capacity building in IEC skills and training in situation analysis and communications planning to develop and implement a comprehensive behavior change strategy at the district level. This will require collaboration among the ZIHP components.

Collaboration Among ZIHP Components. At the national level collaboration between ZIHPCOMM and ZIHPSOM is good. The two agencies have overcome initial tension about their relative roles, fund complementary programs targeting youth, and collaborate in research studies and communication interventions. The joint planning and funding of the HEART campaign by CBOH, ZIHPSOM and ZIHPCOMM is an excellent example of this collaboration.

ZIHPCOMM, ZIHPSOM and ZIHPSERV have also collaborated in fostering social change in communities, with training by ZIHPCOMM in PLA complementing social marketing promotion (ZIHPSOM) and health worker training (ZIHPSERV). However, ZIHP does not appear to have a clear-cut strategy for linking national and local interventions to foster behavior change, partly because of weaknesses in coordinating the activities of the different ZIHP components.

Conclusions and Recommendations

Behavioral change interventions have been of very high quality, well designed based on research findings and a clear conceptual framework, and effective. Research has shown

that viewing and listening to mass media and social marketing interventions correlates with behavior change in terms of condom use. ZIHP should be commended for its focus on continuing research that feeds back into program design.

ZIHP's support for youth organizations has also been very effective in institutionalizing input from youth into youth programs, and in extending the number and reach of materials aimed at youth. However, organizations outside Lusaka are not aware of programs and materials developed by the Lusaka youth organizations, and are not in contact with them.

- **Recommendation:** Networking mechanisms and co-training arrangements to link youth organizations should be supported through YAO, and the distribution system for materials should be expanded to include provincial- and district-level youth-focused NGOs.

Coordination of behavioral change activities between ZIHPCOMM and ZIHPSOM is good, and the two agencies have overcome initial tensions. Coordination to integrate behavior change approaches into district-level interventions still needs to be strengthened.

- **Recommendation:** Systems are not yet in place to build the capacity of DHMTs and NGOs to analyze the behavior change environment and to develop long-term communication strategies at the district level. The peer educator and social marketing approach needs to be balanced by behavior change interventions based on a deeper analysis of how to influence community norms. There should be a greater focus on IEC capacity building. ZIHPCOMM plans to work with DHMTs and communities to develop plans based on the SCOPE planning tool. ZIHPCOMM should give priority to this program, and should ensure that there are adequate follow-up and supplementary training in communication approaches, as defined by the district situation analysis.

On a practical level, there are few HIV/AIDS programs targeting primary school-age groups and their parents as an entry point for building healthy safer sex behavior and changing community norms.

- **Recommendation:** Both ZIHPSOM and ZIHPCOMM are developing projects that will target the primary-school-age group, particularly in rural areas. They should collaborate with USAID's program with the Ministry of Education and ZIHPSERV's EBA and NGO activities, to explore ways to reach this age group; for example, promoting anti-AIDS clubs at the primary school level through the Child-to-Child program.

Cultural and gender issues have affected reaction to messages and programs. Two examples are the recent withdrawal of some condom TV spots aimed at young women, and the mixed reaction of communities to women's participation in community youth camps.

- **Recommendation:** ZIHP should continue to be sensitive to the balance between stimulating behavior change and pushing change too fast in relation to gender and cultural issues, particularly around condom use. This is a difficult issue to manage, as the debate around controversial issues can create also awareness and push forward change. Making certain that leading Ministry officials (Education, Health, Information) have actually viewed all material to be broadcast would be a good insurance policy, as is ensuring that any controversial items are run in late evening time-slots.

4.1.5 Technical Assistance to Designated Partners

Introduction

As part of ZIHP's strategy to increase the demand for and strengthen the provision of high-quality health services in the demonstration districts, ZIHP provides technical assistance and grants to support NGOs and CBOS to carry out community-level interventions. ZIHP has provided direct grants to some NGOs and has also charged selected NGOs with managing and supervising sub-grants to NGOs/CBOs at the district and community level. The design of the NGO grants program requires close interaction between selected NGOs and the DHMT to support integrated district planning and management. NGOs are selected by the DHMT, and lead NGOs have the responsibility to work with the health clinic as well as the community in estimating supply needs and in providing training to their sub-grantee NGOs, thus encouraging an active working relationship.

Many CBOs lack technical and organizational skills. In order to strengthen their capacity through a sustainable mechanism, ZIHP selects Technical Support Organizations (TSOs) as the primary mechanism to upgrade the skills of NGO and CBO grantees working in HIV/AIDS, child health and nutrition, integrated reproductive health, and malaria.

Key Findings

As of March 2001, a total of $855,000 has been awarded to 25 organizations within the 12 demonstration districts. 45% of these work in HIV/AIDS, 24% in Child Health/Nutrition, 21% in IRH, and a small number in water and sanitation and malaria. To date only two organizations, the Copperbelt Health Education Project (CHEP) and Chikankata Health Services, have been selected to be TSOs for NGOs working on HIV/AIDS. There have been some difficulties in identifying NGOs with the technical capability to be mentors that meet USAID's institutional criteria.

ZIHP has also provided technical assistance to CMAZ in managing a separate direct grant from USAID to provide sub-grants to NGOs working in hard-to-reach areas on PHN activities. The program has four sub-grantees: DAPP, World Vision International, Christian Children's Fund (CCF), and ADRA.

The concept of providing technical assistance created initial difficulties in the relationship with long-standing NGOs like CMAZ and CHEP that have considerable technical experience. These were resolved with CMAZ through the signing of a Collaborative Agreement that defined the different roles of the two groups.

The quality and usefulness of technical assistance provided by ZIHP also strengthened good working relationships. The team heard strong, positive comments about the institutional technical assistance provided by ZIHP. This included a wide range of support – for strategic planning, training in financial management, joint review of NGO performance using the PIR, training in institutional systems (including documentation and dissemination), TOT skills, and technical training in HIV/AIDS. One small NGO, SCAN, commented that PIR training had built their self-esteem. Two examples of a multiplier effect from this training include CHEP's use of skills learned in training for their wide network of NGOs, and SCAN's successful proposal to train 42 Rainbow Group members in the PIR. TSO staff are often called on to facilitate and co-train at ZIHP workshops.

The TSO system is fairly new, so it is not possible to judge its effectiveness in training other NGOs or in documenting and disseminating best practices. However, ZIHP should address the tension caused by unforeseen requests to implementing partners to attend or facilitate at workshops on very short notice. This has frequently conflicted with the partners' own priorities.

However, some issues raised by CBO sub-grantees may suggest ways that ZIHP can provide additional TA to strengthen the capabilities of their NGO mentors. CBOs need

training in supervision skills for their own teams of volunteers and peer educators, additional institutional training and support, and more efficient systems for funds disbursement from the lead NGO. In addition, one CBO mentioned need for training to understand the implications of new technical issues like MTCT. ZIHP can work with lead NGOs to identify these areas and develop lead NGO capacity to respond to these needs.

Conclusions and Recommendations

ZIHP has provided significant initial technical assistance to its major NGO partners in building their managerial and technical capacity in a range of areas. Training in the PIR was particularly effective and appreciated. There are already examples of the multiplier effect of this training.

- **Recommendation:** Document the multiplier effect of ZIHP technical assistance as far as possible, for instance through requesting information from TSOs and lead NGOs on their use of ZIHP skills and approaches in other contexts.

ZIHP NGO grants and TA programs have contributed to the empowerment of various NGOs/CBOs, and have increased their outreach, particularly in the delivery of HIV/AIDS services.

- **Recommendation:** Over the next two years, ZIHP needs to address issues of sustainability to assist CBOs to continue activities, particularly those CBOs that are not church-supported. ZIHP should provide ongoing mentoring to CBOs in resource mobilization skills, and should review NGO/CBO financial management capabilities to assess which organizations could graduate from sub-grant status to direct funding.

ZIHP's mechanism of funding small NGOs/CBOs through lead NGOs has caused problems for some organizations, particularly those in remote rural areas, and these problems have sometimes affected carrying out activities. It is time-consuming, expensive, and risky for CBOs to travel long distances to pick up funds. Funds are also frequently late in arriving, which makes it especially difficult for groups with so few resources.

- **Recommendation:** ZIHP should work with lead NGOs to identify some alternative ways to channel funds to this level, such as designating an institutional "holding point" for funds in the community.

ZIHP's focus on achieving results conflicts with the need to move at a pace that recognizes the coordinating role of its partners, and also fits with their schedules and human resource capabilities. Short-term notice of technical assistance activities has also created some tensions. These concerns about partnership were expressed at both the DHMT and coordinating NGO level.

- **Recommendation:** ZIHP should review the joint planning process for NGO activities with DHMTs and TSOs, and improve on communication issues. USAID should also review its measures for assessing ZIHP performance to include assessments of ongoing partnerships. While this may reduce quantitative results, it will likely increase sustainability, which is probably a more important indicator.

4.2 ZIHP Management and Collaboration

Implicit in the ZIHP Program concept, structure and implementation is a requirement for both intensive management and a high level of collaboration among the four ZIHP cooperating agencies. This section deals with both of these dimensions of management and

collaboration from an overall ZIHP perspective. In order to avoid duplication, the management of the four ZIHP technical areas (HIV/AIDS, integrated reproductive health, child health and nutrition, and malaria) is discussed within the corresponding subsections of this report (4.1.2.1 through 4.1.2.4).

4.2.1 Internal ZIHP Management

The following subsections summarize the scope and complexity of the management and collaboration within the ZIHP Program itself, in order to function effectively and achieve the intended program results.

4.2.1.1 Overall Coordination of ZIHP and ZIHP+ Program.

The ZIHP Program itself comprises four cooperating agencies (CAs), each of which focuses its resources on one of four interrelated components. Given the independent nature of the contractual relationships, the Chiefs of Party (COPs) of the four CAs were initially confronted with having to develop a functional relationship that would allow each CA to draw on the considerable resources and expertise of the other three organizations, since many program results require close collaboration among the four components. At the same time, each CA requires a certain degree of independence to carry out its own programs within the overall ZIHP framework.

Discussions with the ZIHP COPs and others make it clear that coordination among the four ZIHP cooperating agencies in managing the overall program was obviously initially a major challenge. It took essentially the first year for the four entities to work out a mutually acceptable form of internal management that encouraged synergy among the four, but also provided the required measure of individual organizational autonomy. This is partly because only one entity had a stipulation in its contract to ensure coordination among the four. Also, the four have equal status, with none as the principal agency or prime contractor.

After two years of working together, the four entities have made the necessary adjustments and have mutually achieved a workable level of collaborative management and program implementation. As indicated throughout this report, there are many examples of the positive impact of this collaboration in what ZIHP has achieved. However, there are still acknowledged tensions among the four entities, and the ongoing collaboration requires considerable time and energy to maintain.

While the collaborative environment that has evolved is now working well, it is not because of formalized managerial linkages among the four entities. In fact, based on the COP interviews, the four CAs clearly prefer ZIHP's informal consortium mechanism to a formal prime contractor/subcontractor arrangement. This is partly because each would want to be the prime contractor, and partly because components that are subcontracted can be limited in scope and prominence by the prime contractor – often to the detriment of overall program balance and impact. The Assessment Team identified three important factors that have made the successful collaboration work: (1) guidance and direction from the USAID Mission, (2) the unique combination of individual personalities and skills among the COPs, and (3) the sheer organizational will among the four CAs to make it work.

If USAID/Zambia is confident that these three factors will continue to exist in another ZIHP-type program after the current program ends, then the advantages of the ZIHP-type collaborative arrangement will continue to exist, and future program objectives should be met. Otherwise, a more formalized management structure will be necessary to ensure the successful management of the technical assistance program that will follow the conclusion of

ZIHP. This kind of arrangement would also streamline the management of the program by USAID/PHN. The risk of not increasing the degree of formalization of the overall management structure is that the critical collaboration will not be sufficient, and the program's results will not be fully achieved. If this option were chosen and this situation arose, then USAID would probably want to amend the contractual arrangements of each CA in order to formalize the management structure.

- **Recommendation:** Should the GRZ and USAID/Zambia decide to continue a ZIHP-type program after the current program ends, USAID will need to be careful in the planning and procurement of technical assistance to ensure that the needed collaborative linkages exist in the new program. Otherwise, some contractual amendments may be necessary to ensure an overall management structure that will produce the collaboration required to achieve the program results.

The second dimension of overall coordination involves the linkages between the ZIHP Program and the several field-support-funded cooperating agencies that are working in Zambia, which collectively have come to be known as "ZIHP+".[16] Some of these cooperating agencies were operating in-country prior to the implementation of ZIHP. Each ZIHP+ organization focuses on a specific, specialized area of technical assistance that supports USAID/Zambia's overall program of assistance. The range includes specialized technical areas (e.g., micronutrients), management (e.g., health logistics management), and operations research (e.g., quality assurance). Further details concerning the relationship between ZIHP and the ZIHP+ entities are included in Section 4.2.2.4 below.

Some of the ZIHP+ agencies are more closely linked to the ZIHP Program than others, and several operate essentially on a national scale. The fact that their relationships with ZIHP are so varied complicates the way in which collaboration works among them. Although the scopes of work of the ZIHP+ entities typically extend beyond that of the ZIHP Program, many are now working at the district level as well.

As noted, while some of the ZIHP+ CAs are providing highly specialized technical assistance and focusing on operations research, others are providing planning and management TA that could be incorporated into the scope of work of one or more of the new ZIHP-type entities. For example, among the current ZIHP+ CAs, the logical scope of work that might have been incorporated into ZIHPSYS would be that of RPM+. Similarly, the HIV/AIDS policy work being done by the Policy Project could have been incorporated into ZIHPSYS. The advantage of including program elements like this into a ZIHP entity is that they can be more carefully focused on the specific needs of the ZIHP Program in supporting the sector-wide approach. In addition, reducing the number of ZIHP+ CAs would decrease the number of management units in the USAID/PHN Office, and thus reduce the management burden.

- **Recommendation:** Should the GRZ and USAID/Zambia decide to continue a ZIHP-type program after the current program ends, USAID should consider integrating selected high-priority skills necessary to support the major ZIHP-type implementation components into the contractual scopes of work of the ZIHP-type contractors. However, field-support-funded CAs may still be the best mechanism for obtaining other, more specialized skills required for programs that extend beyond those of the ZIHP-type program.

[16] There are eleven cooperating agencies with in-country staff that USAID/Zambia includes in the ZIHP+ group: Applied Research in Child Health (ARCH), JHPIEGO/MNH, JHPEIGO/TRH, IMPACT, Micronutrient Operational Strategies and Technologies (MOST), Rational Pharmaceutical Management Plus (RPM+), Linkages, the Policy Project, Health Policy and Systems Strengthening, JHU/PCS, and the International AIDS Alliance. In addition, four other field support CAs support the Zambia program but do not have an in-country presence: the Quality Assurance Project, DELIVER, HORIZONS, and Synergy.

4.2.1.2 Individual Management of the Four ZIHP Cooperating Agencies

As just described, the ZIHP model relies on strong collaboration among the four CAs in order to function effectively. However, the management structure and function of each ZIHP entity can also have an effect on the others.

Based on group discussions with the four COPs and their deputies, and with the four USAID/PHN cognizant technical officers (CTOs), the Assessment Team concluded that the management of the four entities varies considerably. This is to be expected among four different contractors, and is not a problem with truly internal management.

USAID and ZIHP have developed a number of mechanisms to help ensure full coordination across the four ZIHP components. These include: (1) a single ZIHP workplan that integrates all four CA activities and results to be achieved; (2) biweekly meetings among the ZIHP COPs where joint issues are discussed; (3) joint technical working groups; and (4) weekly USAID/PHN staff meetings where the four ZIHP CTOs report on individual meetings with their ZIHP counterparts.

Nonetheless, there is sometimes a tendency for each ZIHP entity to focus on achieving its own workplan agenda, and each does not always adequately take into account the activities of the other three – and the linkages and interrelationships among them -- in achieving the overall ZIHP workplan objectives. This situation is complicated by the fact that the five IRs represent the primary dimension by which achievement is measured, and most of these require major contributions by several contractors.

- **Recommendation:** In workplan planning, execution and monitoring, ZIHP and USAID/PHN should ensure that each ZIHP entity is managed in such a way that each is fully involved and working collaboratively to create the synergistic effect necessary to achieve the indicated results.

4.2.2 Relationship Between ZIHP and Key Partners

4.2.2.1 Government Partners

ZIHP enjoys a cordial relationship with its Government partners. ZIHP collaborates with Ministry of Health, Ministry of Education and Ministry of Science and Technology. The collaboration with the Government of Zambia is through a bilateral agreement with the US Government. This agreement stipulates the areas of support that the US Government provides to the Government of Zambia. A Memorandum of Understanding which the Ministry of Health has signed with its Cooperating Partners enhances the agreement at Government level in the health sector. The MOU stipulates that all Cooperating Partners will buy into the National Health Strategic Plan. The ZIHP Program forms part of the agreement between GRZ and the US Government .

ZIHP is currently providing technical support to the Ministry of Health and Central Board of Health nationally and in 12 demonstration districts. This includes working with MOH/CBOH and District Health Management Teams (DHMTs) on policy and systems development, planning and budgeting, capacity building, quality assurance etc. Other districts also benefit from ZIHP activities because of spin-off effects in key areas, and ZIHP is now including neighboring districts in several implementation activities. As noted above, ZIHP also provides technical assistance to the central level in planning and policy development, as well as in the four technical areas. ZIHP also collaborates with the GRZ through the CBOH technical working groups, the Basket Steering Committee, etc. Further, ZIHP collaborates with the Medical Council of Zambia (MCZ), the General Nursing Council (GNC), Chainama

College for Health Sciences, and various nursing colleges in curriculum development for pre- and in-service training. ZIHP also collaborates with the Tropical Disease Research Center (TDRC) and National Food and Nutrition Commission (NFNC) on Vitamin A.

In HIV/AIDS prevention, ZIHP collaborates with the HIV/AIDS/STD/TB Council and Secretariat. In addition, there is also collaboration with the Ministry of Education especially primary and secondary schools in the same technical area. Schools have formed Anti-AIDS clubs which have been instrumental in the preventing this disease. ZIHP has also trained employer-based agents from both public and private sectors. These agents are providing services in the four technical areas to their fellow employees.

- **Recommendation:** Even though there is good collaboration between ZIHP and the GRZ partners in many areas, ZIHP and the CBOH need to integrate and coordinate activities better. This will provide efficiency gains, foster a stronger partnership, and ensure sustainability of the activities ZIHP is currently supporting. Thus, during the remaining two years of ZIHP, CBOH and ZIHP should work on improving this coordination and integration, and in planning and implementing activities together.

4.2.2.2 NGOs and Private Sector

One of ZIHP's key roles has been to help government by expanding the involvement of the private sector and NGOs in financing and delivering health services. ZIHP is helping the GRZ to increase the number of workplaces receiving HIV/AIDS services, as well as to increase the number of private-sector service delivery channels providing PHN interventions. In this way, ZIHP contributes to the Health Reform vision by increasing access to health services.

Earlier sections of the report have highlighted a number of examples in which primarily ZIPHSERV has been working to expand the role of the private sector and NGOs. However, ZIHPSOM also supports the private sector strategy by targeting the workplace as a point of sale for socially marketed products and information. ZIHPSOM also provides training to Employer Based Distributors (EBDs) so that they can provide useful information and advice, as well as health promotion materials, to their workplace clients.

ZIHP also works with the demonstration districts to improve the ability of traditional healers to provide services and appropriate referrals. In addition, work has begun to define the needs of private medical practitioners and to develop strategies for strengthening their focus on primary care services.

- **Recommendation:** ZIHP should continue to strengthen partnerships that will expand and improve the delivery of community-based health service by involving communities, CBOs, NGOs, traditional healers and the DHMTs. ZIHP should also continue to provide needed technical assistance to CBOs, NGOs, and Church Organizations/Churches, including CMAZ.

4.2.2.3 Cooperating Partners

Introduction

Over the past decade, the GRZ's cooperating partners have played a major role in supporting the Zambian health sector. Cooperating partners currently contribute approximately 45% of the GRZ budget for health services. At present, some 30% of all hospital beds are operated through private-sector (primarily church-related) institutions.

Major GRZ cooperating partners are providing a wide spectrum of programs which require coordination with ZIHP initiatives:

- **DANIDA:** Focus on policy, sector-wide planning and basket funding, with emphasis on district health services. Specific project and technical assistance for capacity building include policy development, management and financial administration.
- **SIDA:** Focus on policy and sector-wide planning and basket funding, with emphasis on district health services. Specific project activities include policy development, planning and capacity- building initiatives within the MOH and CBOH.
- **DFID:** Focus on policy, sector-wide planning and basket funding, with emphasis on district health services. Specific project and technical assistance include policy development, planning and capacity building at CBOH, technical and facility support for the improvement of PHC, youth-friendly HIV/AIDS initiatives, provision of FP commodities and selected drugs (TB emphasis), and improvements in logistics management.
- **Irish AID:** Focus on policy, sector-wide planning and basket funding, with emphasis on district health services. Specific project activities include improving medical laboratory services, reproductive health services and district health management.
- **JICA:** Specific project activities include equipment, commodity and transport improvements for the national and district malaria programs; laboratory training and improvements; diarrheal disease and nutrition services; and the HIV/AIDS program (border initiative).
- **UNICEF:** Initiatives include assistance with sector-wide planning and basket funding for district health services, as well as support for child health and nutrition, and integrated STD, HIV/AIDS and IEC programs/materials;
- **Others:** Specific programs between GRZ and UNFPA, WFP and Dutch AID also require ZIHP-related coordination in the areas of family planning, women's health, improved nutrition (micronutrients), and health care reform.

Key Findings

In collaboration with the USAID/Zambia Mission, ZIHP has developed a number of effective coordinated programs and collaborative activities with several key cooperating partners:

- **JICA/ZIHP:** JICA and ZIHP work extremely effectively in the implementation of malaria control initiatives with JICA providing transport, laboratory equipment (microscopes), bed nets and commodities to support the activities of the CBOH and the DHMTs. ZIHP provides the marketing skills, training and organizational capacity for the highly successful social marketing of ITNs.
- **DFID/ZIHP:** DFID and ZIHP have developed a highly successful relationship to increase the provision of condoms and contraceptives for HIV/AIDS and STD prevention/control and family planning. DFID provides condoms and ZIHP provides social marketing skills, training and organizational capacity for a very successful condom social marketing program.
- **DANIDA/SIDA/ZIHP:** DANIDA, SIDA and ZIHP have developed effective collaboration in providing technical assistance for improved policy and planning within the MOH/CBOH.
- **UNICEF/ZIHP:** UNICEF and ZIHP work closely together in a number of child health and nutrition programs, particularly in support of the planning, implementation and evaluation of Child Health Week and National Immunization Days (NIDs).

Despite these collaborative efforts between ZIHP and many of the GRZ's cooperating partners, when the Assessment Team met with the above cooperating partners as a group, the majority expressed concern over the current ZIHP design because it continues to emphasize projectized development assistance. These donors feel that ZIHP deviates from the prevailing approach of the majority of cooperating partners who support the sector-wide

approach (SWAp) and basket-funding strategies. Several major European donors and UN organizations are opting to provide the majority of their funds through the SWAp and basket-funding mechanisms based on the following principles:

- In the long term, support for the national strategic plan is more effectively, efficiently and beneficially accomplished through SWAp and basket-funding mechanisms.
- ZIHP-like projectized assistance often establishes new operational structures which parallel those of the GRZ, and which typically do not provide optimal institutional sustainability and support for the MOH/CBOH.
- Projects create problems of equity between selected and non-selected geographical areas or target populations;
- Projectized aid compromises long-term sustainability benefits in favor of short-term improvements.
- Projects substitute short-term (3-5 years) outcome indicators for longer-term (3-10 years) impact measurements related to sector-wide systemic changes and overall health status changes.
- Projectized aid is characterized by costly technical assistance, while basket-funding focuses on the existing service delivery system, which does not have such high personnel costs associated with it.
- Projects usually come with significant administrative and financial restrictions that reduce program flexibility and may slow program implementation.
- Projectized aid routinely requires expensive expatriate staff to manage the complicated development assistance packages, while SWAp and basket-funding approaches utilize the government's existing accountability, management and monitoring mechanisms.
- Projects frequently do not make explicit many of the costs of achieving results. They also tend to distort salary levels towards international standards, which are generally not sustainable.

The cooperating partners stated that, in fairness, one could develop a similar list of points in favor of the project approach to development assistance. One key advantage is that projects or programs, such as ZIHP, tend to (and should) provide world-class technical and management experts who can assist developing country counterparts to develop creative solutions and systems that will overcome health system problems and limitations. The fact that many of the GRZ's cooperating partners have linked their programs with ZIHP would seem to underscore the utility of high-quality project technical assistance when effectively combined with other approaches.

In the joint meeting with the Assessment Team, the cooperating partners agreed that USAID and ZIHP have made major contributions to the improvement of specific health sector interventions. The partners also indicated that they were struggling with methods to evaluate the short- and long-term impact of the SWAp and basket-funding approaches. Several donors stated that, in the long term, they believe that donor assistance will evolve to a compromise position between the SWAp approach and projectized assistance. However, these donors strongly believed that the preponderance of the development funds to the health sector would and should progressively move towards the SWAp and basket-funding approaches.

Conclusions and Recommendations

As just noted, ZIHP is currently collaborating with many cooperating partners in implementing effective joint activities. Strong and effective collaborative efforts have been developed and are contributing to improved and expanded services in the areas of malaria, HIV/AIDS, IRH, and child health and nutrition.

- **Recommendation:** As opportunities arise, ZIHP should expand its collaborative linkages with key cooperating partners. As with other assessment recommendations, ZIHP should document the effectiveness of and lessons learned from these collaborative efforts, including clear estimates of programmatic and/or health impacts and program costs.

For the reasons cited in the findings outlined above, the trend among the GRZ's cooperating partners is to commit a greater percentage of development resources towards SWAp and basket-funding approaches. However, the programs of all of the cooperating partners who met with the team also include projectized and/or long-term expatriate technical assistance components.

Another important factor is that since 1999, via its Sector Program Assistance mechanism, USAID has budgeted approximately $2 million per year, or 10% of its total annual health program funding, directly to the district basket. A total of $2 million has been disbursed to date under this arrangement.

Unfortunately for the ZIHP Program, the district-basket-funding mechanism is used to fund the regular activities of the DHMTs nationwide, including a small percentage the DHMTs pass on for community-based activities. Based on information from the Assessment Team's field trips, the problem is that the basket-fund allocations from the CBOH represent only a fraction of the DHMTs' budgets, and the DHMTs must make difficult choices in allocating these funds among their priority needs. Typically these funds go towards salaries and other critical needs, and there are insufficient funds for program support, especially at the community level.

- **Recommendation:** The joint GRZ-USAID design of the ZIHP Program specifically envisioned a cost-sharing approach by the GRZ to provide those programmatic resources (drugs, transport, etc.) that complement ZIHP's planned inputs. Since the absence of these programmatic resources is clearly a critical problem affecting ZIHP Program implementation, the MOH/CBOH and USAID should determine the reason(s) that they aren't available from the GRZ as anticipated, and rectify the situation.

- **Recommendation:** Because of the relative importance of SWAp and basket-funding approaches, ZIHP should offer to collaborate in the planning and evaluation of these programs at district, provincial and national levels. In addition, ZHIP should assist the GRZ, where feasible, to document the effectiveness of these efforts in terms of both short- and long-term improvements in the health system, and the resultant health impact.

4.2.2.4 Field Support-funded Organizations

Introduction

The assessment team met with representatives of six of the field-support-funded CAs that currently have programs in Zambia. These agencies collectively have come to be known as "ZIHP+." Some complement the ZIHP program and fulfill specific technical needs which would have been difficult to obtain directly through the ZIHP project. Others have national-scope operations research and programmatic functions that are not linked to the ZIHP Program. Representatives from the following projects were interviewed: ARCH, JHPIEGO/MNH, Linkages, MOST, Policy Project and RPM+.

Key Findings

ARCH is doing applied research in child health and HIV/AIDS, and is helping the CBOH with the national research agenda. They are also providing TA and funding to the National Malaria Control Center, ZIHP and other partners on malaria-related issues.

JHPIEGO/MNH focuses primarily on maternal and neonatal health through a number of activities, including helping the General Nursing Council to strengthen its curricula, introducing post-abortion care (PAC) to all district hospitals, and launching the white ribbon campaign in Zambia to promote safe motherhood.

The Policy Project is working in human rights and HIV/AIDS issues and will pilot a manual on human rights in the workplace. The Policy Project has also developed the AIDS Impact Model (AIM) booklet for Zambia.

MOST is working with ZIHP and the government on strategies for twice-yearly Vitamin A supplementation and Vitamin A sugar fortification.

RPM+ is giving TA to the CBOH in rational drug use. They will also help the NMCC to scale up when the first-line drug for treating malaria is changed, and will provide drug management support of the IMCI program.

Linkages has established a demonstration project at an antenatal clinic in Ndola District to better respond to the HIV-related needs of women, with a special focus on infant feeding.

All of the field-support-funded CA representatives that the team interviewed had voluntarily established their offices in the ZIHP building where three of the four ZIHP contractors reside. All of the representatives felt that it was to their advantage both financially (e.g., sharing communications and other costs) and in terms of ease of coordination with different components of ZIHP. While significant amounts of time are needed for coordination, none feel it to be an imposition and feel that it only serves to strengthen their activities. The ZIHP+ representatives sit in on certain of the COP meetings and sit with the districts during their planning process to ensure there is no duplication, and that the districts have the capacity to handle all activities.

Conclusions and Recommendations

The various connections between the ZIHP+ activities and ZIHP are too complex to capture or describe easily, but all are in some way collaborating with, joint funding with, or otherwise coordinating with ZIHP. This kind of coordination is rarely seen with USAID-funded programs in other countries, and is very beneficial in terms of avoiding duplication, capitalizing on complementary skills and interests, and having maximum impact on the population served. In summary, the field-support-funded projects are filling a technical assistance niche and coordinating well with the ZIHP Program.

- **Recommendation:** With the proviso noted in Section 4.2.1.1, USAID should continue to use field support projects as needed to provide priority, specialized technical assistance to complement the overall USAID/Zambia PHN program.

4.2.3 Relationship Between ZIHP and USAID/Zambia

Based on interviews with both the ZIHP COPs and their deputies and the USAID/PHN Cognizant Technical Officers (CTOs), the working relationship between ZIHP and USAID/Zambia is generally both cordial and effective. However, the USAID/PHN managers have both technical and management responsibilities. Heavy workloads in both areas often compete with one another and sometimes affect the ZIHP relationship and ZIHP program

management. Each of four USAID/PHN managers has CTO responsibility for one of the ZIHP Program entities (e.g., ZIHPCOMM), but as reported by the ZIHP COPs and deputies, typically the technical responsibilities of the CTOs don't correspond well with their ZIHP management responsibilities. As viewed by ZIHP, despite significant improvements within the last year, the overall result is that the working and managerial relationships for the four ZIHP entities are not uniformly strong and effective.

- **Recommendation:** Notwithstanding the need for technical responsibilities among the USAID/PHN professional staff and the existence of competing priorities among the staff's overall management roles, USAID/PHN and ZIHP should jointly develop ways in which the four USAID CTOs can be more effective in managing their respective ZIHP entities. This should include creative ways to improve coordination both among themselves and with their ZIHP counterparts, in order to optimize the interrelationships among the four ZIHP components. Ensuring that the biweekly ZIHP COP/Deputy and USAID/PHN CTO meetings are held would also help. Modifying overall work responsibilities of individual CTOs may be needed in order to make the workloads more manageable.

4.2.4 Data Management Systems

Data management systems within ZIHP itself are of two types: (1) systems for managing and monitoring ZIHP Program activities, and (2) internal, organizational data management systems for managing each of the ZIHP agencies. The Assessment Team has been asked to assess only the first kind of system. [Note that ZIHP's activities related to the GRZ Health Management Information System (HMIS) have been discussed in Section 4.1.1.5.]

Conclusions and Recommendations

ZIHP and its collaborating organizations have designed and implemented systems for managing and monitoring ZIHP Program activities at all levels. This includes DHMTs, NGOs, CBOs, community health facilities and NHCs. Although the team found that it was usually impossible to obtain data in the field (other than "charts on the wall") from most of these entities on short notice (since the person responsible wasn't available), one exception was the information available from ZIHPSOM. First, ZIHPSOM field representatives usually had key statistics and information in their heads -- sales figures and trends, quantities of each product sold and in stock, etc. In addition, when visiting the ZIHPSOM district offices in the Copperbelt, this information was readily available, and based on discussions with ZIHPSOM staff (including an overview of stocks on hand), it appeared to be valid.

- **Recommendation:** ZIHP should work with its partners in the field to ensure that the value of management information is understood, and that the information is readily available for program planning and implementation, as well as for monitoring and evaluation purposes.

5. FUTURE DIRECTIONS FOR USAID PHN ASSISTANCE

5.1 Option of a One-year Extension of ZIHP

As described in Section 4, the Assessment Team has concluded that the ZIHP Program is making many significant contributions to the Zambian health sector in achieving the NHSP, especially in the areas of capacity-building and increasing community-level involvement in their own health. However, there are both positive and negative factors that must be weighed carefully in assessing whether ZIHP should be extended beyond the current four-year time frame.

The positive considerations include the following:

- Owing largely to its comprehensive program and managerial complexity, ZIHP got off to a slow start and didn't really achieve full implementation capacity until the end of its first year. Thus, an additional year would allow for four full years of effective implementation, and would help to ensure that ZIHP achieves the intended results.
- A fifth year would allow additional time to operationalize the shift in program philosophy described in Section 4 to better meet the challenges and needs of the GRZ in achieving its strategic plan.
- A five-year time frame for ZIHP would coincide with USAID/Zambia's proposed one-year extension of its Country Strategic Plan (CSP) cycle, and would provide a logical point at which a new program should start.
- Given the complexity of the current ZIHP Program and the likely complexity of the future assistance package, an additional year would provide sufficient time to conceive, plan and design the new program so that there would not be a detrimental gap in USAID's support to the GRZ health sector.
- A fifth year would also provide a more realistic time frame for expanding the assignment of ZIHP technical experts to work directly with their CBOH and MOH counterparts on a long-term basis directly in CBOH/MOH, and to provide capacity-building support so that the counterparts are better able to carry out their responsibilities once the ZIPH experts depart.
- A fifth year would also allow the GRZ and ZIHP to focus on building capacity -- especially training capacity -- at the provincial level during the next three years so that a significant level of sustainability would be achieved in mutually agreed, high-priority program areas by the end of the extended ZIHP Program.

The Assessment Team also acknowledges several negative factors:

- ZIHP's focus on technical assistance makes it an expensive form of support to the GRZ, compared with funding additional GRZ staff positions via the basket-funding approach. Thus, a fifth year would serve to increase the overall cost of USAID assistance via ZIHP. [Note that this point is not based on an analysis of cost-effectiveness.]
- According to some MOH and CBOH officials, the ZIHP Program is not integrated within the National Health Strategic Plan to the extent that the GRZ would like it to be.
- Based on discussions with the Assessment Team, some MOH and CBOH officials at central level have the perception that the way ZIHP is implemented, it has become almost a "parallel structure" alongside that of the Central Board of Health.
- Thus far, there has been a lack of transparency in providing cost information relating to the implementation of ZIHP. Without this cost information, the GRZ cannot assess the overall effectiveness of ZIHP interventions, and cannot adequately plan for institutionalizing ZIHP activities into its ongoing programs.

- The GRZ would like to make the transition to a new framework of assistance as early as possible.

- **Recommendation:** Given this complex range of considerations, and within the short timeframe of this assessment, the Assessment Team could not reach a consensus and thus cannot make a recommendation either to extend or not extend the ZIHP program for a fifth year. The team therefore recommends that the GRZ and USAID begin now to consider the above factors and others that may influence the decision of whether to extend ZIHP or not, and reach a fully reasoned decision in the near future.

- **Recommendation:** Whether or not the GRZ and USAID decide to extend the ZIHP Program for a fifth year, this mid-term assessment has provided many good ideas on how the current ZIHP Program might be modified and focused during the remaining two or three years. A fifth year would allow these programmatic shifts to achieve more impact and perhaps prepare the way for the new program of assistance, but even without a one-year extension the changes would make a difference in overall ZIHP achievements and tangible benefits to the GRZ. Among the recommendations made in Section 4, many fall into the following categories:
  - Based on mutual agreement, focus on a limited number of interventions that represent the highest-priority areas of support.
  - Plan, budget for, and coordinate ZIHP program resources together with the GRZ and/or cooperating partner resources that are required ("backup support") to implement these priority programs effectively at central, provincial, district and community levels.
  - In particular, focus on capacity building (especially training capacity) at the provincial and/or district levels, so that there is a reasonable level of sustainability at these levels by the time the current ZIHP Program ends.
  - Increase the number of ZIHP technical experts working with MOH/CBOH counterparts on a long-term basis. Success thus far in the policy area has been impressive and the assistance has made a difference.

- **Recommendation:** The team also recommends that the GRZ and USAID/Zambia urgently undertake the conceptualization, planning and design of USAID's future program of assistance to the GRZ, so that there will be a smooth transition from ZIHP to the new program.

5.2 Program Assistance After ZIHP

During discussions on the nature of future program assistance with both GRZ and USAID officials and others, the Assessment Team heard a wide variety of opinions and suggestions. The key underlying issue that appears to influence people's responses is their perception of the extent to which -- and how effectively -- the current ZIHP Program meets the objectives of the NHSP; in other words, ZIHP's contribution to GRZ health reform. Another key factor is the question of technical assistance in relation to the alternative SWAp and basket-funding approaches. A third, interrelated point relates to ZIHP's contribution to the long-term sustainability of the GRZ health care system.

One important consideration affecting these factors is the general framework through which USAID provides development assistance. As a result of US Congressional requirements and USAID assistance parameters, most USAID development assistance to most countries is in the form of programmatic support rather than basket funding. For a variety of reasons, it is not likely that this situation will change in the foreseeable future, although USAID's contribution to basket funding in Zambia is an example of USAID's flexibility in meeting

national program priorities. Therefore, GRZ and USAID negotiations on future assistance should make effective use of USAID's technical assistance capabilities by combining them effectively with both GRZ resources and those of other cooperating partners and other agencies.

USAID technical assistance programs tend to (and should) provide world-class technical and management experts who can assist developing country counterparts to develop creative solutions and systems that will overcome health system problems and limitations. In other words, USAID's program focus can and does support the sector-wide approach (e.g., policy and planning assistance, health logistics systems development, private-sector involvement). As discussed in Section 4.2.3.3, the fact that many of the GRZ's cooperating partners have linked their programs with ZIHP would seem to underscore the importance of high-quality ("project") technical assistance when effectively combined with other approaches and resources. Clearly, these synergistic kinds of partnerships should continue to be pursued in developing the next program of assistance.

During the discussions, there seemed to be a lack of recognition by some officials of the collaborative nature of the original ZIHP design, and what the design required in terms of providing resources, and by whom. As noted in the Executive Summary and reflected in many of the Assessment's recommendations, many GRZ officials at central, provincial and district levels were concerned that the ZIHP Program didn't provide all the necessary backup support (drugs and supplies, transport, etc.) that were required to complete ZIHP field activities. This was often characterized as providing the training for health and community workers to learn new skills, but not the "tools" they needed to practice those skills. However, the joint GRZ/USAID ZIHP Program design clearly indicated that ZIHP would be responsible for certain inputs (typically training and technical assistance) and the MOH/CBOH would be responsible for others (typically the needed "tools"). In other words, the intended mix of resource contributions hasn't consistently worked well, in most cases because the DHMT (or other GRZ entity) did not have the budgetary resources to provide the backup support when needed. As noted in other sections of the report, there were also a number of occasions when ZIHP activities were delayed, and the required GRZ resources weren't available on short notice to meet the revised implementation schedules. In designing the next program of assistance, the GRZ and USAID must carefully analyze the reasons for the difficulties that have hampered the current ZIHP Program implementation, and must identify workable solutions for these problems and incorporate them in the new design.

- **Recommendation:** Given the nature of USAID's worldwide program assistance mechanisms, USAID/Zambia's new health program should be built around a core of high-quality technical assistance, linked to other resources that together can have a major impact in helping the GRZ to achieve its NHSP. The ZIHP Program has demonstrated the value -- both operationally and programmatically -- of the integrated program approach, and implementation has generally been very effective. The GRZ and USAID should learn from the lessons of the first two years of the ZIHP Program and should design a future program that capitalizes on ZIHP's most effective strategies and overcomes its limitations.

As discussed in Section 4.2.1.1, the collaboration among the four ZIHP CAs is working well because of the existence of three key factors: USAID guidance and direction, the unique combination of COP personalities, and the organizational will among the four entities to make it work. If USAID/Zambia is confident that these factors will be present in a follow-on ZIHP-type program, then the advantages of the ZIHP-type collaborative arrangement will help ensure that future program objectives will be met. Otherwise, a more formalized management structure will be necessary to ensure the successful management of the technical assistance program that will follow the conclusion of ZIHP.

- **Recommendation:** The team feels that the continuation of a comprehensive, integrated health program makes sense in the Zambian context. Based on the inputs the team received during many interviews and meetings during the review, USAID should consider using a ZIHP-like organizational structure to implement the future program of assistance with the GRZ. If the same kind of creative and resourceful implementation arrangement exists, it will go a long way in helping to achieve the results of the new program of assistance; if not, USAID should consider modifying contractual and/or management arrangements among the ZIHP-like entities to ensure effective program implementation. Finally, if USAID and the GRZ wish to continue or initiate other programs outside of the scope of the ZIHP-type program (e.g., the program for orphans and vulnerable children), other procurement mechanisms could be used.

5.3 USAID/PHN Office Management and Staffing

The complexity of ZIHP and its many dimensions makes the program both complicated and difficult for USAID/PHN to manage effectively. The four PHN Cognizant Technical Officers (CTOs) responsible for ZIHP management are each assigned to manage one of the four institutional entities that comprise the areas of functional support (ZIHPCOMM, ZIHPSOM, ZIHPSERV and ZIHPSYS). This is somewhat dysfunctional, since the primary ZIHP performance framework is by intermediate result (IR). This makes it difficult to manage for accountability, since more than one entity often has responsibility for contributing to achieving the result.

- **Recommendation:** Future annual workplans submitted to USAID/PHN should indicate the ZIHP entity primarily responsible for achieving the stated result, as well as the others that contribute to it. [The Assessment Team understands that ZIHP produces a version of the workplan that provides this information, but uses it for internal management.] This primary entity should then be held accountable for achieving the result, although it will require a collaborative effort among two or more entities to accomplish it, and similarly will require intensified managerial coordination (including among the USAID/PHN CTOs and the ZIHP COPs) .

The conclusion and recommendation in Section 4.2.3 (concerning the relationship between ZIHP and USAID/Zambia) is also relevant to this section, since it has an impact on overall management of ZIHP by USAID/PHN. For a CTO, the competing priorities between ZIHP management responsibilities and other technical and management responsibilities may simply be a function of overload. Part of the problem may also derive from gaps in internal coordination within USAID/PHN (e.g., limited communication among CTOs where there are important programmatic linkages). In any case, the competing priorities and/or overload factors detract from the collective potential for USAID/PHN to manage the complex ZIHP Program more effectively.

- **Recommendation:** USAID/PHN should reassess the management roles among its managers, and prioritize them to ensure the effective management and implementation of the ZIHP Program. If this requires the addition of staff who can focus on ZIHP Program management, this option should be considered. The recent decision to add a second person within USAID/PHN to help cover HIV/AIDS is one example of the recognition of the problem noted and its possible resolution. Another option would be to add one or two staff members within USAID/PHN at the “Activity Manager” level. This would provide backup to the CTOs and ensure that day-to-day management activities are completed in a timely way, thus allowing the CTOs to focus on more complex issues.

Owing to time limitations in the overall assessment, financial management within USAID/PHN was not a specific focus of the assessment. However, one situation became apparent that suggests that USAID/PHN should assess adequacy and the equity of the overall allocation of funds among USAID/PHN programs, and in particular among the four ZIHP entities. The situation is complicated by the fact that, for a variety of reasons, the level and timing of funds allowances from USAID/Washington do not coincide with those planned for. This is a worldwide phenomenon, and includes three important dimensions: (1) funds are received later than they should be, (2) funding levels may be reduced from those anticipated (even earlier in the fiscal year), and (3) the earmarks[17] of funds actually received may be different from those planned. The ZIHP Program example has to do with the apparent shortage of USAID/PHN funds during the allocation of available program resources before the FY01 funds become available between now and September. The outcome thus far has been that at least partly because of the nature of the procurement mechanisms among the ZIHP entities, Abt Associates (the single contract) has been threatened twice during the last year with not having sufficient funds to continue operations, and they are currently in that position. Should the situation progress to the point where Abt Associates would have to interrupt the continuity of its support to ZIHP, it would have serious implications for the overall ZIHP Program.

- **Recommendation:** USAID/PHN should analyze its overall budgeting and allocation mechanisms to ascertain the source of the current difficulties, and should take measures to ensure that the situation doesn't continue.

[17] "Earmarks" are USAID's way of designating the purposes, or kinds of programs, for which the U.S. Congress has determined that overall health sector funds must be spent. Matching these earmarks to the funding of programs has become an increasingly difficult process, since the levels of specific earmarks of funds allowed may have changed significantly from the time programs were designed.

ANNEX 1

ZIHP MID-TERM ASSESSMENT SCOPE OF WORK

March 6, 2001

I. BACKGROUND

In 1991 Zambia embarked on an ambitious vision for health reform to provide **equitable access to cost effective quality health care as close to the family as possible**. The Ministry of Health vision is to 1) create environments conducive to health; 2) disseminate knowledge on the art of being well; and 3) ensure equitable access to an essential package of integrated health care services. Within the context of health reform, there is a reorientation from highly centralized vertical programs to decentralized integrated programs. The major components of GRZ's health reform are:

- Decentralization
- Financial and performance accountability
- Redirection of funding to the primary care levels of service delivery
- Defining 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
- De-linkage of personnel from the civil service
- Donor coordination

To support these reforms, USAID/Zambia developed a **strategic objective (SO), Increased use of integrated child, reproductive health and HIV/AIDS interventions**, in partnership with the GRZ, other donors and partners. This should lead to the goal of sustainable improvements in the health status of Zambians. Contributing to the SO are five intermediate results. The IRs are:

- **Intermediate Result #1**: Increased demand for PHN interventions among target groups.
- **Intermediate Result #2**: Increased delivery of PHN interventions at the community level.
- **Intermediate Result #3:** Increased delivery of PHN Interventions by the private sector.
- **Intermediate Result #4**: Improved health worker performance in the delivery of PHN interventions.
- **Intermediate Result #5:** Improved policies, planning and support systems for PHN interventions.

In October 1998 USAID entered into agreements with three organizations (Johns Hopkins University Center for Communications Programs, John Snow Inc. and Abt Associates) to implement the Zambia Integrated Health Program (ZIHP). A fourth component (Society for Family Health/Population Services International), which was on going at the time, was folded into the program as well. These four components have been designated:

1. **ZIHPCOMM** – Communication and Community Partnership which is implemented by the John Hopkins University Center for Communication Programs, with Care International, Africare and Manoff.

2. **ZIHPSERV** – Service Delivery and NGO Strengthening which is implemented by John Snow, Inc., with CARE International, Initiatives Inc., Manoff, and the International HIV/AIDS Alliance.

3. **ZIHPSYS** – Policy, Planning and Systems Support which is implemented by Abt Associates with Pathfinder International, Initiatives Inc., American Manufacturers Export Group (AMEG) and the University of Zambia.

4. **ZIHPSOM** – Social Marketing which is implemented by the Society for Family Health and Population Services International.

The main objectives of ZIHP are to increase quality coverage of health interventions in the districts and communities by strengthening programmatic links with District Health Management Teams (DHMTS), health centers and communities and their partners in the implementation of health interventions. ZIHP aims to empower individuals and communities to practice, or support the practice of healthier behaviors and to access health services in a timely and appropriate fashion. ZIHP also seeks to increase DHMT's capacities to respond to the needs of hard-to-reach communities.

ZIHP follows an integrated approach with special attention to the following technical areas:

- HIV/AIDS
- Malaria
- Child Health and Nutrition
- Integrated Reproductive Health

ZIHP provides assistance to Zambia's health programs at the national, provincial, district and communities. Special attention is given to twelve demonstration districts to enable ZIHP to help the GRZ to test new methodologies, to identify successful strategies and to achieve health impact at the community and the household level, through the implementation of the basic health care package in those districts. The demonstration districts are: Chama, Chibombo, Chipata, Kabwe, Kalomo, Kasama, Kitwe, Livingstone, Lundazi, Mwense, Ndola, and Samfya.

ZIHP produces one joint work plan and three of the components share common workspace. Joint management meeting are routinely conducted as well as joint retreats. The common vision of ZIHP is to work closely as one program to achieve health improvement in Zambia.

II. OBJECTIVES

The overall purpose of this assessment is two fold. First to review the past two years of ZIHP operations and provide an assessment of performance, lessons learned, and areas of improvement. The second objective is to provide USAID with input to the design of future assistance to the Government of Zambia after the end of the existing ZIHP program.

The specific objectives of the assessment are to:

Part One

1. Review and comment on the integrated vision of ZIHP. What have been their achievements in carrying out the five Intermediate Results (IRs). To what extent is ZIHP achieving results in the four technical areas of HIV/AIDS, malaria, child health and nutrition,

and reproductive health? (Please comment on people-level impact as much as possible) What could be done to improve performance?

2. Given the central role that behavioral change plays in the objective of the PHN Strategic Objective, review ZIHP's activities in this area and comment on their effectiveness. Has the behavioral change activities and approaches been well coordinated between ZIHPCOMM and ZIHPSOM and how has behavioral change approaches been integrated into the other ZIHP components?

3. Review and comment on the management structure of the overall ZIHP Program as well as the management organization of the four ZIHP components.

4. Review the present structure of the four technical working groups and various sub-teams, e.g. Community partnership, works within ZIHP and make recommendations on ways that they can be improved.

5. Assess the relationship of ZIHP with other key partners, including among others the CBOH, MOH, District Health Teams in Demonstration Districts, other donors, and private companies involved in workplace programs.

6. Review the effectiveness of ZIHP in providing technical assistance to various designated partners and make recommendation for ways to improve coordination.

7. Assess the relationship between ZIHP and USAID cooperating partners working in Zambia with Global Bureau field support funds. Is there adequate coordination of activities? Are they complementary?

8. Review the data provided by each component of the ZIHP program and comment on the quality of data provided to USAID for performance monitoring.

Part Two

1. Provide recommendations of future direction for USAID assistance in the PHN sector after the ZIHP program ends FY 02. What should be similar or different from the ZIHP model? Identify key issues that a follow-up design team would need to consider in the program development. Include discussion of PHN management burden for different options.

2. Comment on the option for extending the current ZIHP program by one year for a total of five years LOP.

3. Review the overall management structure and staffing of the USAID/PHN Office and make recommendations for the future, taking into account anticipated funding levels over the next five years.

III. TIME LINE OF ACTIVITIES

Team Visit in Zambia	March 5-23, 2001
- Team Building Session	March 5-6, 2001
- Information Sessions	March 7-9, 2001
- Field Trips	March 12-16, 2001
- Follow-up Visits and Report Writing	March 19-23, 2001
Final Report Submitted	April 30, 2001

V. TEAM MEMBERSHIP

Outside Experts

- Mr. Alan Foose - Team Leader/Management Expert
- Dr. Janet Hayman - HIV/AIDS/ Behavioral Change Expert
- Ms. Alix Grubel - Reproductive Health Expert/Writer
- Dr. Jim Sarn – Policy/System Support Expert

In Country Experts

- Dr. Simon Miti – CBOH
- Mr. Davies Chimfwembe – MOH
- Dr. Godfrey Biemba – CMAZ
-

Total Size: Seven

VI. SPECIFIC REQUIREMENT FOR LOCAL HIRE ZAMBIAN STAFF

The local hire Zambian staff is expected to fully participate in the Mid-term assessment of ZIHP. Specific areas of focus will be determined during the team planning meeting to be held on March 5 and 6. They will be expected to attend all appropriate meetings and provide written input to the final report as requested by the team leader. They will also be required to submit an expense report by March 30, 2001.

VII. LEVEL OF EFFORT

The local hire Zambian staff will be expected to work up to 18 working days. This depends on the final schedule that will be developed during the team planning meeting.

ANNEX 2

SUMMARY OF SUPPLEMENTAL CONCLUSIONS AND RECOMMENDATIONS

This summary of supplemental conclusions and recommendations is organized in the same way as the major conclusions and recommendations in Section 2. Thus, they are grouped under the titles of their respective report sections.

IR1: Increased demand for PHN interventions among target populations (4.1.1.1)

ITNs were introduced into some communities nearly one year ago, but re-treatment issues were not discussed by NHC members during our field visits. We also found some stock-outs of re-treatment tablets.

- **Recommendation:** The Assessment Team understands from ZIHP that materials on re-treatment have been developed and that ensuring re-treatment of ITNs has proved to be a difficult issue worldwide. In Zambia, other malaria net programs that have tried to promote re-treatment have only achieved 1% re-treatment rates. Recognizing these problems, the team is pleased to note that promoting re-treatment after 3 washes will be a priority for ZIHPSOM this year, as our field experience confirmed that NHCs need to be more aware of its importance.

IR2: Increased delivery of PHN interventions at the community level (4.1.1.2)

In addition to the development of the initial draft plans, the Zambian planning process is viewed as a series of negotiation steps between various levels of the health sector. There were concerns expressed by district-, provincial- and national-level officials regarding the overall participation of ZIHP in the "negotiation process" involving the role of partners in the development of final plans and budgets. ZIHP was seen as coming into the preparation of the Action Plan at the national and district levels with an already prepared menu or agenda of activities (particularly training, social marketing, IEC and high-level technical assistance). The ZIHP menu of activities was not always seen as complying with the priority needs of the province, district or community, particularly in providing balanced "capacity" and "operational" needs and their associated budgets to support the ZIHP activities.

- **Recommendation:** ZIHP should continue the early inputs into the improvement of planning skills at the level of the community, district and national level. However, ZIHP should consider expanding its support for the service-delivery-related activities of the respective Action Plan. For example, ZIHP inputs into the Action Plans should assure that capacity enhancement skills being developed in IMCI and IRH training initiatives can be fully utilized. If the new skills can't be fully utilized in carrying out programs for lack of other resources, the health workers can't be fully effective, and may lose the skills quickly. To help ensure program impact, continuity and sustainability, overall program resource needs must be met. The GRZ, USAID and ZIHP should assess the reasons that needed backup support (drugs, basic equipment, transport, etc.) are not available, and should provide supplemental resources from among available options. At the same time, ZIHP should work with DHMTs and NHCs to encourage longer-range planning to make sure that resources that could be provided by them will be available when needed.

- **Recommendation:** ZIHP should introduce basic cost-effectiveness, cost-efficiency, cost-benefit and sustainability skills into the peer review, technical assistance and learning methodologies being implemented in all demonstration districts.

DHMT officials have indicated that ZIHP training materials and training programs have made a major contribution to the improved technical capability of CHAs and DHMT staff. Some 240 TOT and 5300 community health agents/workers have been trained to enhance the PHN services in some 2200 NHCs.

Although ZIHP-trained staff indicated their appreciation for their improved technical skills, DHMT staff and health workers alike have also reflected a need to be provided with increased drugs, equipment, transport and communications in order to fully utilize newly acquired skills and to reach the full potential for health service provision

- **Recommendation:** To help ensure program impact, continuity and sustainability, overall program resource needs must be met. The GRZ, USAID and ZIHP should assess the reasons that needed backup support (drugs, basic equipment, transport, etc.) are not available, and should provide supplemental resources from among available options. At the same time, ZIHP should work with DHMTs and NHCs to encourage longer-range planning to make sure that resources that could be provided by them are available when needed.

ZIHP has identified a number of effective national-level NGOs to facilitate the delivery of PHN services in both high-risk and hard-to-reach areas. At a national level, key NGOs such as the Churches Medical Association of Zambia, Africare and World Vision International are working with ZIHP to provide and monitor grants to local NGOs and CBOs. In addition, ZIHP is supporting a number of key NGOs, including Africa Alive and Trendsetters, to provide a national IEC platform to disseminate key health messages, particularly to youth groups.

At the district and community level, ZIHP has identified and provided support to mature, church-related organizations and newly emerging “specialized NGOs” such as the HIV/AIDS organization Thandizani in Lundazi. These efforts have begun to extend the delivery of services to remote communities in the areas of child and reproductive health, HIV/AIDS and a variety of IEC initiatives. In addition, the social marketing activities of SFH with these local organizations has significantly extended the distribution of ITNs, Clorin and contraceptives.

- **Recommendation:** In districts where ZIHP has selected a “lead” NGO, ZIHP must give increased attention to the suitability of the selected NGO. Many NGOs which have been selected as initial agencies for ZIHP support, particularly at the district and community levels, tend to be highly effective, one-dimensional organizations and cannot be effective models or fully represent the multi-faceted capabilities of ZIHP to other NGOs. ZIHP needs to extend assistance to the widest possible spectrum of NGO organizations within the technical areas of the program.

- **Recommendation:** As ZIHP is not likely to open offices in each demonstration district, ZIHP should give consideration to developing the capacity within local government entities, particularly the DHMT, to recruit/mobilize, managerially strengthen and provide grant support to local NGOs to reach high risk areas.

ZIHP has been effective in strengthening the capacity of the DHMT to coordinate and facilitate community-planning inputs into the District Action Plans. This occurs primarily through the development of PLA skills at the community level, and through provision of technical assistance to the Action Plan process.

ZIHP has not had a noticeable impact on the improvement of the health care referral system for clinical care from the community to the district hospital. Basic improvements to the clinical care continuum are considered vitally important by all members of the health care team, from the NHC to the health center to the district hospital and to the DHMT.

IR3: Increased delivery of PHN interventions by the private sector (4.1.1.3)

In some of the districts visited there were stockouts of certain products, especially ITNs and certain brands of contraceptives. In addition, at the chlorine production factory in Kitwe, they had run out of bottles and had to stop packaging Clorin to wait for bottles to be delivered from Lusaka.

- **Recommendation:** ZIHPSOM is currently working to eliminate such problems. They should continue modifying the forecasting system and addressing other problems to ensure a constant supply of products.

Employer-based programs and the FACEAIDS project are both effective workplace initiatives with peer education and distribution of reproductive health commodities.

- **Recommendation:** FACEAIDS could be strengthened through a stronger focus on family planning and the employer-based program could be strengthened through a stronger focus on HIV/AIDS education and prevention. These programs should share materials and lessons learned.

The peer educators in the FACEAIDS and employer-based programs are not being effectively supervised.

- **Recommendation:** ZIHP should develop mechanisms that will assist the DHMT to improve the supervision of peer educators.

It is rare for traditional healers to participate on NHCs or as CHWs.

- **Recommendation:** The traditional healers' curriculum should be developed by adapting the CHW curriculum. This would not only ensure that the traditional healers are reinforcing the messages of the CHWs, but would also be realistic and cost-effective.

Private medical practitioners are an untapped resource in Zambia. Training of these practitioners is crucial but takes them away from their jobs for a long time.

- **Recommendation:** Find a way to make a training program acceptable to private providers without taking them away from their jobs for long periods of time. Consider evenings, weekends, self-paced distance learning, etc.

IR4: Improved health worker performance in the delivery of PHN interventions (4.1.1.4)

ZIHP has significantly contributed towards the improvement of the General Nursing Council supervisory functions through facilitation of its Strategic Plan, development of a Monitoring and Evaluation tool, and dissemination of the Nurses and Midwives' Professional Code of Conduct.

The DHMTs do not receive information on the cost of ZIHP-funded training, making it difficult for DHMTs to plan and budget for similar training.

- **Recommendation:** ZIHP should be more transparent in the implementation of its training activities, and provide all necessary financial information to the Provincial Health Office and the District Health Office.

IR5: Improved policies, planning and support systems for PHN interventions (4.1.1.5)

ZIHP has invested considerable effort and resources (not quantifiable) in the development, expansion and implementation of existing systems without adequate follow-up. These systems include:

- Quality Assurance
- Performance Audit
- Hospital Accreditation
- HMIS and FAMS
- Planning

- **Recommendation:** ZIHP should provide follow-up and supportive supervision in order to sustain interventions such as quality assurance and accreditation. ZIHP should also consider providing resources to continue the accreditation program.

Most ZIHP capacity-building activities in districts are not fully funded. The co-financing creates a problem in the sense that if districts do not have enough funds then these activities cannot be implemented, or if implemented they are not sustainable.

- **Recommendation:** All ZIHP-supported activities should be 100% funded so as to avoid delays in their implementation in cases were the district doesn't have sufficient funds for co-financing.

All the districts visited indicated that they were experiencing delays in the availability of funds for ZIHP-supported activities. In one instance, activities which were to be carried out in the first quarter ended up being implemented in the fourth quarter. This situation created pressure for districts, and often interfered with completing action plan activities on time.

- **Recommendation:** Release of funds to ZIHP-supported activities should be timely so as to avoid implementation pressure arising from most of DHMT activities being implemented in the last quarter. Early release of funds can be a source of motivation to CBDs.

There has been a tremendous response from NHCs in supporting community-based health activities such as the selling of ITNs. Community Health Workers seemed to understand their roles. However, the incentive behind the commitment appeared to be the profit rather than their own contribution to better community health.

- **Recommendation:** ZIHP should explore ways and means of coming up with other incentives for CHWs in addition to sharing profits from social marketing product sales.

HMIS data are generally captured from the demonstration districts through follow-ups and supportive supervision. As noted above, the HMIS system is becoming increasingly more effective. However, the reliability of these field data should be verified on a sample basis.

- **Recommendation:** ZIHP should explore ways and means to come up with measures -- including strengthening the supportive supervision system -- that will ensure that the data collected are both reliable and accurate.

Technical Area 1: HIV/AIDS (4.1.2.1)

ZIHP could consider collaborating with the International HIV/AIDS Alliance to strengthen the community response to AIDS, by using the Alliance's participatory methodology to identify needed prevention and care activities at community level and the potential roles of community organizations, which could then be fed back into ZIHP training modules. Two examples of community approaches in neighboring countries provide an idea of the potential scope: (1) in one area in Tanzania, community organizations were led through a mapping exercise that identified situations that encouraged high-risk behavior and proposed ways to reduce risk; and (2) communities in Zimbabwe have set aside communal land to help support affected families.

ZIHP is supporting several NGOs whose programs could provide models for scaling up in other areas. For example, Thandizani and Moomba, two church-based NGOs/CBOs, are effectively providing VCT services and care and support at the community level. Also, SCAN is working with street-kids.

- **Recommendation:** The Assessment Team supports ZIHP's plans to document the Thandizani model in a case study. ZIHP could also work with other NGOs to document replicable experiences and better practices and support them in networking with similar organizations to identify common challenges and successful approaches.

There are still few PLWA groups outside the main urban areas.

- **Recommendation:** Strengthen networking for existing PLWA groups with NGOs working on HIV/AIDS prevention and care at the local level, and in particular, link local NGOs with the ZIHP+ program on legal rights for PLWAs. CHEP and PLWA projects visited were unaware of this project.

Much of USAID's HIV/AIDS program is outside ZIHP (such as the SCOPE Project) or is carried out primarily by other partners, with input from ZIHP. For example, ZIHP works with World Vision on the border project. ZIHP has also been a successful partner in developing community mobilization and male involvement strategies for the Ndola Demonstration Project.

- **Recommendation:** ZIHP should continue to link closely with these other research and community-level projects, in particular those addressing VCT, care and support. ZIHP should also ensure that lessons learned about both implementation and research are fed back into ZIHP's training program; for example, incorporating the experiences in promoting male involvement and community mobilization around MTCT into community training modules.

A lot of resources have gone into technical support through training workshops. However, expanding outreach by NGOs (such as Thandizani in Lundazi District) has been limited by several factors, including transport.

- **Recommendation:** More CHWs and TBAs need to be trained to make follow-up of AIDS cases easier. To help ensure program impact, continuity and sustainability, overall program resource needs must be met. The GRZ, USAID and ZIHP should assess the reasons that needed backup support (drugs, basic equipment, transport, etc.) are not available, and should provide supplemental resources from among available options.

Technical Area 2: Integrated Reproductive Health (4.1.2.2)

ZIHP is contributing to an increase in the contraceptive prevalence rate in Zambia; however, the fertility rate remains high and contraceptive prevalence rate remains low. While integrating services sometimes offers more opportunities for reaching clients with family planning education and services, FP activities are frequently becoming sidelined within ZIHP activities where many other important health services are being offered. For example, during field visits, NHCs talked about many activities spontaneously but needed to be prompted to talk about FP.

- **Recommendation:** Within the reproductive health portfolio (and especially during training of health workers), try to emphasize family planning and its positive effect on other health issues such as child health, maternal health, etc.

Although Depo-Provera has been approved for use in a demonstration district in the Copperbelt Province (under Pop Council/CARE activities) it is currently not legal for national distribution in Zambia. This obviously limits the choice of contraceptives available to women (an element of quality of care). Once legalized, Depo-Provera is likely to be a very popular option as it has been in many other African countries.

- **Recommendation:** Work with the CBOH to lobby for the prompt legalization of Depo-Provera within Zambia.

There are several areas where socially marketed IRH products could be promoted through the private sector.

- **Recommendation:** Promote socially marketed IRH products through FACEAIDS, traditional healers, private practitioners, etc.

According to current Zambian law, EHTs are supposed to be providing promotive and preventive health care services only. However, through ICT training they are being taught limited curative health interventions, and because they are often the only providers in their health centers, they often end up providing such services.

- **Recommendation:** ZIHP should help the government to revise legislation and/or regulations so that EHTs registered with the Medical Council of Zambia can legally provide curative services appropriate to their training.

Many cadres of health workers are being trained but they complain that when they return to their posts, they are unable to practice what they have learned due to various reasons such as lack of equipment, supplies or finances to implement.

- **Recommendation:** To help ensure program impact, continuity and sustainability, overall program resource needs must be met. The GRZ, USAID and ZIHP should assess the reasons that needed backup support (drugs, basic equipment, transport, etc.) are not available, and should provide supplemental resources from among available options.

TBA training has caused great demand in the districts for further TBA training.

- **Recommendation:** Although data in Zambia show that training of TBAs has not impacted on the maternal mortality rate, ZIHP nonetheless is under pressure to scale up TBA training. ZIHP should advocate to partners to collaborate on alternative programs to reduce the maternal mortality rate.

Technical Area 3: Child Health and Nutrition (4.1.2.3)

Major improvements have occurred in IMCI guidelines, training and supervision initiatives at the DHMT and community levels. DHMT and community health workers interviewed by the Assessment Team believe that their preventive and diagnostic capabilities have been improved significantly through ZIHP-supported training. Trained individuals indicated that ZIHP or DHMT supervisors had achieved at least one follow-up consultation during the past year. ZIHP-trained community and clinical health workers indicated that additional supportive supervision was needed to ensure ongoing improvements in technical capacity development. These improvements are critical in order to deal with the scope and scale of child health and nutrition problems that the health workers encounter.

- **Recommendation:** ZIHP program activities should make every effort to ensure that increased supportive supervisory visits occur with trained personnel to assure appropriate in-service training support. Supervisors should review clinical and CHW client records; discuss difficult diagnosis, care, prevention and referral cases; and provide appropriate guidance to staff and volunteers.

ZIHP-trained personnel and DHMT officials indicated some concern with the protocols recommended by the ZIHP-sponsored training regarding presumptive treatment for malaria for every fever. Clinical officers indicated that many of the presenting fevers needed additional diagnostic considerations, and that over-prescription of malarial drugs might hasten resistance.

- **Recommendation:** ZIHP trainers/officials should review the training curriculum and diagnostic/treatment protocols regarding fever presumptive treatment and consider the benefit/risks of maintaining/revising the current protocols for specific locations within the provinces/district demonstration areas.

ZIHP-trained personnel and DHMT officials indicated that considerable increases in drugs, equipment, transport and communications equipment were necessary to insure that the appropriate conditions existed to fully utilize their IMCI training.

- **Recommendation:** To help ensure program impact, continuity and sustainability, overall program resource needs must be met. The GRZ, USAID and ZIHP should assess the reasons that needed backup support (drugs, basic equipment, transport, etc.) are not available, and should provide supplemental resources from among available options.

ZIHP has produced a useful array of IEC materials to support ongoing child health and nutrition interventions and Child Health Week. These include posters, print, radio, interpersonal communications materials, laminated cards for CHWs, distance education materials, dramas, the Better Health Campaign, and related programs on IRH, malaria and HIV/AIDS.

ZIHP materials in support of child health which were available in the clinics and in community locations, while of high quality, were generally in English, and were generally in short supply or unavailable.

- **Recommendation:** ZIHP child health IEC programs and materials should be made more readily available for all CHW and clinic facilities in the demonstration districts and, where appropriate, translated into the local written languages.

ZIHP has been very effective in promoting child health and nutrition PLA and NHC planning and implementation activities in coordination with the DHMTs. These activities have

generally included support to both communities and DHMTs in strengthening EPI initiatives, diarrheal disease control (Clorin, ORS, potable water and sanitation), growth monitoring, malaria control, ARI, related reproductive health issues and strengthening of nutrition activities, particularly growth monitoring and anemia reduction. Training of staff, HMIS formats, supervision and local planning efforts appear to be well organized throughout the demonstration districts.

Technical Area 4: Malaria (4.1.2.4)

There is some evidence that malaria incidence has been reduced by 5% in Mwase-Lundazi RHC catchment area since the introduction of ITNs, but it is too early to see significant change in overall malaria morbidity and mortality.

Currently, ZIHP works in partnership with JICA in the malaria control strategy, the latter providing transport, equipment and drugs. ZIHP does not provide these items.

- **Recommendation:** ZIHP should continue to foster and strengthen complementary partnerships in the control of malaria.

ZIHP Contribution to GRZ Health Reform (4.1.3)

[No supplemental conclusions and recommendations]

Importance of Behavior Change (4.1.4)

On a practical level, there are few HIV/AIDS programs targeting primary school-age groups and their parents as an entry point for building healthy safer sex behavior and changing community norms.

- **Recommendation:** Both ZIHPSOM and ZIHPCOMM are developing projects that will target the primary-school-age group, particularly in rural areas. They should collaborate with USAID's program with the Ministry of Education and ZIHPSERV's EBA and NGO activities, to explore ways to reach this age group; for example, promoting anti-AIDS clubs at the primary school level through the Child-to-Child program.

Cultural and gender issues have affected reaction to messages and programs. Two examples are the recent withdrawal of some condom TV spots aimed at young women, and the mixed reaction of communities to women's participation in community youth camps.

- **Recommendation:** ZIHP should continue to be sensitive to the balance between stimulating behavior change and pushing change too fast in relation to gender and cultural issues, particularly around condom use. This is a difficult issue to manage, as the debate around controversial issues can create also awareness and push forward change. Making certain that leading Ministry officials (Education, Health, Information) have actually viewed all material to be broadcast would be a good insurance policy, as is ensuring that any controversial items are run in late evening time-slots.

Technical Asistance to Designated Partners (4.1.5)

ZIHP NGO grants and TA programs have contributed to the empowerment of various NGOs/CBOs, and have increased their outreach, particularly in the delivery of HIV/AIDS services.

- **Recommendation:** Over the next two years, ZIHP needs to address issues of sustainability to assist CBOs to continue activities, particularly those CBOs that are not church-supported. ZIHP should provide ongoing mentoring to CBOs in resource mobilization skills, and should review NGO/CBO financial management capabilities to assess which organizations could graduate from sub-grant status to direct funding.

ZIHP's mechanism of funding small NGOs/CBOs through lead NGOs has caused problems for some organizations, particularly those in remote rural areas, and these problems have sometimes affected carrying out activities. It is time-consuming, expensive, and risky for CBOs to travel long distances to pick up funds. Funds are also frequently late in arriving, which makes it especially difficult for groups with so few resources.

- **Recommendation:** ZIHP should work with lead NGOs to identify some alternative ways to channel funds to this level, such as designating an institutional "holding point" for funds in the community.

Overall Coordination of ZIHP and ZIHP+ Program (4.2.1.1)

[No supplemental conclusions and recommendations]

Individual Management of the Four ZIHP Prime Contractors (4.2.1.2)

[No supplemental conclusions and recommendations]

Relationship Between ZIHP and Government Partners (4.2.2.1)

[No supplemental conclusions and recommendations]

Relationship Between ZIHP and NGOs and the Private Sector (4.2.2.2)

[No supplemental conclusions and recommendations]

Relationship Between ZIHP and Cooperating Partners (4.2.2.3)

[No supplemental conclusions and recommendations]

Relationship Between ZIHP and Field-Support-Funded Organizations (4.2.2.4)

[No supplemental conclusions and recommendations]

Relationship Between ZIHP and USAID/Zambia (4.2.3)

[No supplemental conclusions and recommendations]

Data Management Systems (4.2.4)

[No supplemental conclusions and recommendations]

Option of a One-year Extension of ZIHP (5.1)

[No supplemental conclusions and recommendations]

Program Assistance After ZIHP (5.2)

[No supplemental conclusions and recommendations]

USAID/PHN Office Management and Staffing (5.3)

The complexity of ZIHP and its many dimensions makes the program both complicated and difficult for USAID/PHN to manage effectively. The four PHN Cognizant Technical Officers (CTOs) responsible for ZIHP management are each assigned to manage one of the four institutional entities that comprise the areas of functional support (ZIHPCOMM, ZIHPSOM, ZIHPSERV and ZIHPSYS). This is somewhat dysfunctional, since the primary ZIHP performance framework is by intermediate result (IR). This makes it difficult to manage for accountability, since more than one entity often has responsibility for contributing to achieving the result.

- **Recommendation:** Future annual workplans submitted to USAID/PHN should indicate the ZIHP entity primarily responsible for achieving the stated result, as well as the others that contribute to it. [The Assessment Team understands that ZIHP produces a version of the workplan that provides this information, but uses it for internal management.] This primary entity should then be held accountable for achieving the result, although it will require a collaborative effort among two or more entities to accomplish it, and similarly will require intensified managerial coordination (including among the USAID/PHN CTOs and the ZIHP COPs) .

ANNEX 3

ASSESSMENT METHODOLOGY

In accordance with the elements of the scope of work, the assessment methodology comprised the following approaches.

Facilitated team-building exercise. USAID/PHN had contracted a local professional facilitator to work with the Assessment Team in a variety of team-building exercises during the first day and a half of the assessment period. Since the team was comprised of seven people, most of whom didn't know each other, this exercise was an opportunity for the team to learn about each other and work together in thinking through the assignment to follow.

Formal presentations by ZIHP and USAID/PHN. During the next few days of the first week, ZIHP made formal presentations on the overall ZIHP Program and its components, followed by a seried of in-depth discussions with each of the four ZIHP entities in order to present more detailed information on the ZIHP Program. The in-depth discussions were presented in four concurrent groups, so each team member participated in the groups that were relevant to the team member's major assessment responsibilities, including report writing. The structure of the sessions allowed each team member to participate in two of the five IR presentations, as well as two of the four key technical areas. USAID/PHN also made a formal presentation of its program, staffing and management. All of these sessions, and the materials related to them, were critical to giving the team a jump-start in obtaining an understanding of the complexities of both the ZIHP and overall USAID/PHN programs.

Field trips. ZIHP and USAID/PHN had planned several optional field trip itineraries for the second week of the assessment period. Since the Assessment Team during Week 2 comprised six people, the team divided into two groups of three, and with advice from both ZIHP and USAID staff, they chose two different itineraries. One field team chose a five-day trip that included travel to the Copperbelt Province, and on their return a one-day stop in Central Province. In Copperbelt Province both the provincial health office and the two districts visited were in urban and peri-urban areas. By contrast, both the provincial health office and the DHMT areas visited in Central Province offered a truly rural setting. The second field team chose Eastern Province, and in their six-day field trip they spent time traveling through two rural districts that demonstrated well the difficulties of providing health services in a sparsely populated rural environment. Both teams developed formal and informal protocols for conducting interviews and meetings with Government officials, NGO and CBO representatives, and a wide range of communities during their respective field trips.

Meetings and interviews. In addition to the meetings and interviews carried out during the field trips, the team members (as a full team, in smaller groups and individually) held meetings and interviews in Lusaka with a wide range of officials and individuals among the MOH, CBOH, cooperating partners, PVOs/NGOs and other organizations. Team members also made follow-up visits to both ZIHP and USAID/PHN staff members in order to clarify points and obtain more in-depth information. These meetings and interviews were a primary tool for gathering information on the current status of the ZIHP Program, as well as for obtaining insights and suggestions for current program improvements and future directions.

Review of relevant documents. In advance of the Assessment Team's arrival, ZIHP had taken on the responsibility of assembling a wide range of ZIHP and other documents that were relevant to the mid-term assessment. The documents were centralized in a resource

center at the ZIHP building, and were available to the team during the entire assessment period. These documents, as well as others provided by USAID and other organization, were an invaluable source of information.

The combination of presentations, discussions, meetings, interviews, and documents provided the Assessment Team with a virtual mountain of information relevant to the assessment. These combined resources provided a wide range of information on the following areas, all of which formed part of the team's scope of work: (1) Historical perspective, (2) program concept and design, (3) program strategies, (4) activity and program performance, (5) coordination among stakeholders and partners, (6) monitoring and evaluation, and (7) program management at all levels.

Data analysis and presentation. All of the above sources provided the material that the team used to compile, analyze and present the information in the form of this assessment report. Given the time constraints of such an ambitious assessment, the team was able only to develop written conclusions and recommendations before the three-week assessment period ended.

Participant feedback and report revision. Following the team's group work in Zambia, the Team Leader coordinated the initial feedback (on the preliminary conclusions and recommendations), the preparation of a complete draft (including selected feedback), and the finalization of the report based on a final round of feedback.

ANNEX 4

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ANNEX 5

LIST OF INDIVIDUALS INTERVIEWED, BY ORGANIZATION

Organization	Name	Title	Contact
Africa Alive	Clement Bailwya Robert Zulu Brian Chensaca John Phiri Ian Membe Thomas Kapakala Vivien Ngoma	Project Manager Vice Chair Chairman Committee Member Project Coordinator Country Rep Committee Member	789598 430179 096-432593 283421 096-760268 251454 220494
Africa Directions	Evans Banda		320493/4 25443/5
AIDS Alliance	Waneen Kay Polly	Consultant	
ARCH	Elizabeth Berleigh	National Malaria Advisor	262837
Bank of Zambia	Agaster S.C. Mwelwa	Sister In Charge	
Care for Children in Need	Lacarius Shaba		
CB University	Charles C. Mbola	EBD	
CBOH	Dr. Gavin Silwamba Dr. Ben Chirwa Mr. Chulu Agnes Ongalo Monde Luhanga	Director General Dir. Of Clinical Care and Diagnostic Services Board Secretary Nutrition Specialist Adolescent & RH specialist	253180
CHEP	Christopher Chabu Shaddy Chondoka Martin Chisulo Isaac Mumba Nesone Mutale Buwa Edward Mupotola Florence Mulenga Princess Kasune Zulu		
Chibombo DHMT	Kate Bwalya	Acting Director	
Chipata DHMT	Elicho Bwalya J.L. Mwale Herod Mukangwa Patrick Moyo Masozyo Churwa Z. Sumbwalanga Margaret Nkhoma Frank Zyamba	 Clinical Care Specialist Environmental Health Specialist Assistant Accountant Senior Nutritionist Office Assistant Secretary Internal Auditor	

CMAZ	Beatrice Musamba Rosemary Zimba Lameck Zulu	Manager GMU/PDO Monitoring and Evaluation Officer Financial Analyst	229702/ 237328 232850
DAPP/Hope for Humana	Jane Broen Jensen Mercy Kabwe Peter Boonman Poso Ngabande Hilary Muyunda	DAPP Director Positive Living Advocate Development Instructor Health Services Program Leader HOPE 2d Program Manager	
DFID	Tony Daly	Health Advisor	251102
DorcasAid	Charles Mwambo Brenda Kwalombola	Project Manager Project Director	
General Nursing Counsel	Eleanor Judith Msidi Dorcas Phiri Gerfudi Kunda Mwape Stella Chisuka Boastz Kaputa Catherine Mutwale Theresa Kikateyo	Registrar M&E Coordinator Deputy Registrar M&E Officer Accountant Midwife Examinations Officer	097-847158 281651 780413 097-806084 097-805963
Growth Monitoring Post	GM Promoters and mothers attending GM post		
Hosanna	Patrick M'nthanga Barnabas Mwansa Jr.	Project Coordinator Planning Manager	
Irish Embassy	Kevin Carroll	Attache, Development	291124/ 290650
JHPIEGO/MNH	Rick Hughes	Country Director	254555
JICA	Tomoko Sichone	HIV/AIDS/TB Specialist	291075
Kitwe Cental Hospital	Hilda Chelenu Lessy Haziyu F.M. Kangwa	Area Manager Nurse Midwife Clinical Teacher	
Kitwe DHMT	Dr. K. Kanwek M.C. Mkandwire Liyungu Sicwimba Grace Hazembe Mary M.P. Siefa Mundia Lugwendo	Acting Director AMPD Medical Officer Nutritionist AMA DA	
Kwacha Clinic Kwacha Clinic (cont'd)	Chama Chimensu Fred Sampa NHC members	SCO in charge NHC Chairman	
LAWAA	Rose Muyanga	Chairperson	

LDWA	Mercy Tembo	Secretary	
Linkages	Nomajoni Ntombela Hilary Chiyota	Resident Advisor Program Officer	783157
Luangwa Health Center	Bertha Kaluba Violet Senduli	Nursing Sister NHC GMP Coordinator	
Lubuto Clinic	Annie Banda L. Kalenda NHC members	Nursing Sister EHT	
Lumezi Mission Clinic	Sister Ragasiana Kiwamgo		
Lundazi DHMT	Laxon Dhaka Sylvester Nijinenda Tudia Bioke Bilengre Lemi Mulenga	Director Administrative Manager Medical Officer DHIO	
Lundazi Disaster and Development Group	Denny Kamunga	Chairperson	
Lundazi Home Based Care	Evaristo Ndhloru		
Lundazi Nutrition Group	Mundenzo Kuumba	Member	
Lutheran World Services	Sichulwe Shaddeck		
Matete Primary School	Rhoda Katongo Agnes Simeza Grade 4 and Grade 6 members of Anti-AIDS Club	Head Teacher Anti-AIDS Club Coordinator	
MOH	Hon. E.K. Kavindele V. Musowe	Minister of Health Director of Planning and Development	253026
Moomba Home-Based Care	Cephas Musamba George Daka	Coordinator Project Coordinator	
Mopani	Elina Kapota Agnes Katepa	FHN Nursing Officer	
MOST	Chipo Mwela	Field Co-ordinator	
Mthuzi Development Foundation	Jumori Mtongo		
Mtuzi Foundation	Isaac Tindi		
Mulenda	Mr. Fordson A. Nalwimba A. Masulani M. Nkondwa C. Chipatuka R. Mafulauzi	Director Treasurer Coordinator Secretary Committee Member Committee Member	
Mwase Primary Health Centre	Henry Zimba Francis Miete	EHP Nurse/TBA	

National Food and Nutrition Centre	Priscilla Likwasi	Director	221426 096-759858
National Malaria Control Centre	W. Kapelwa S.U. Nkunika G. Sikazwe	Scientific Officer Scientific Officer IEC Specialist	282455
Ndola CBOH	Dr. Peter Mijere P. Mubiana	Provincial Health Director Environmental Health Specialist	
Ndola DHMT	Dr. Mwila Kaunda Lembalemba Lynette Maambo Ronal Maambo Ricky Dinge Ndhlovu L.C. Chirrianga Rose Chilolo Helen Chigulu	Director Community Partnership Coord. AIDS Coordinator District Health Inf. Officer Nursing Services Manager EBD Supervisor Nursing Officer	
NWLA	Aim Banda		
NZP+	Kunyima Lifumbela Joseph Katele Cecilia Wright Matthew Miti	Administrative Secretary Acting Coordinator NZP+ Member NZP+ Member	223152
Planned Parenthood Association of Zambia	John Mukuwa	Chairperson	
Policy Project	Robie Siamwiza	Consultant	097-845666
Radio Chikaya	Oyd Muyanga		
Royal Danish Embassy	Peter Rasmussen	First Secretary	254277
Royal Swedish Embassy	Per Ola Mattsson Mulenga Muleba	First Secretary	
RPM+	Oliver Hazemba	Regional Technical Advisor	254555
SCAN	Rev. John Mubika K.C. Mulenga	Program Manager Project Director	
Society for Family Health	Sohail Agha Brian Mwarsa Charles	Research Director Central Area Manager Copperbelt Area Manager	
Thandizani	Geoffrey Chucujiko	Director	
UNFPA	Beatrice Chikiotola	Family Planning Advisor	251172/5
UNICEF	Jim Mohan	Acting UNICEF Representative	252055

USAID/PHN	Robert Clay Barbara Hughes Peggy Chibuye Karen Shelley Dr. Steve Hodgins	PHN Office Director Deputy Ofc Director Senior Public Health Specialist HIV/AIDS Technical Advisor Child Health Specialist	254303
WFP	Marc Neilson		254332
World Vision	Martin Silutongwe Kwasi Nino Mapanza Nkwilimba Kanyanta Sunkuter Charles Kachikoti	National Director Health Advisor Asst. Field Programs Director Manager-HIV/AIDS Communications Manager	264404 260723/6
YAO	Mukwati Akufuna Hilda Ohliwayo Cheryloo Ngumbe Clement Bwailya	Peer Counselor Programs Officer Senior Programs Officer Project Manager	
Youth Media	Mary Phiri Cathy Phiri	President Information and Publicity Director	
YWCA	Bonity Zulu		
Zambia Red Cross	Harriet Millimo		
ZIHPCOMM	Holo Hochonda Saphira Nachizya Grace Sinyangwe Beene Hang'omba Elizabeth Serlemitsos Lute Kazembe Rose Zambezi	Youth Communications Media Relations Assistant Communication Coordinator, Safe Motherhood Child Health Communications Assistant Chief of Party Men's Package Communication Coordinator Community Partnership Specialist	772604 097-808614 097-777626
ZIHPCOMM/CARE	Juness Kalumba	Copperbelt Area Coordinator	
ZIHPSERV	Catherine Mukakwa Reuben Mbewe Anna Chirwa Andrew Mewa	Community Partnerships IRH Specialist District IRH Specialist NGO HIV/AIDS Support Officer	254553 283896 254552

ZIHPSERV (cont'd)	Mulinta Nyunibu	Private Sector Coordinator	
	Nosa Orobaton	Chief of Party	
	V. Mukaka Chilaika	Deputy Chief of Party	
	Edith Bwayo	Private Sector Specialist	
	Mutinta Nyumbu	Private Sector Coordinator	
	Richard Mwambazi	Driver/EBD Agent	
ZIHPSOM	Margaret Sinieza	Admin. Manager	292443
	Chilufya Mwaba	HIV/AIDS Marketing Manager	
	Brian Moonga	Border Initiative Project Manager	
	Rebecca C. Sakale	Family Planning Operations Manager	
	Chilufya Mwaba	Marketing Manager- HIV/AIDS	
	Nils Gade	Chief of Party	
	Sohail Agha	Regional Research Officer- PSI	
	Sachingongu Nkenda	Research Analyst, SFH	
ZIHPSYS	James Maneno	Quality Improvement Advisor	254555
	Jenny Huddart	District Planning Advisor	
	Cosmos Musumali	Health Policy Advisor	
ZNBC	Martha Nkunika	H. Resources Administrator	
	Florence Hangoma	Producer/EBD	
	Albert Phiri	Regional controller	