ADRA ZAMBIA
CHILD SURVIVAL XV PROJECT
Chipata and Chadiza Districts, Eastern Province

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THIRD ANNUAL REPORT

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ADRA/Zambia Child Survival (CS) XV Project
Third Annual Report
(October 1, 2001 – September 30, 2002)

Executive Summary

Main activities in year three of ADRA Zambia CS XV Project comprises of the following:

1) Malaria Intervention: Malaria Information, Education and Communication (IEC) activities were carried-out by trained Community Health Workers (CHWs), Traditional Birth Attendants (TBAs), Neighbourhood Health Committee (NHC) members, headmen, traditional healers in their respective areas of operation. However, these messages were more intensified by women's groups trained in malaria education and marketing of mosquito nets. The use of mosquito nets in communities increased steadily from 20% in the second year to 40% this year. Trained women's groups and clubs sold 717 new bed-nets and re-treated 477. CHWs reported that 26,642 households use mosquito nets out of a total household population of 74,088.

2) Maternal And Child Health (MCH) Intervention: TBA reports indicate that 3,137 home deliveries were conducted, 12 of which were both fresh and macerated stillbirths. The fresh stillbirths were caused by mal-presentations, prolonged labour as well as prematurity. Normally, TBAs are supposed to deliver only women who are not at risk at home and refer the rest to the nearest health facility. However, sometimes they are called to attend to an emergency delivery of women at risk resulting in stillbirths. This year, CHWs reported a total of 2,702 births, and 186 under-five deaths (inclusive of stillbirths). No maternal deaths occurred. But miscarriages increased to 39. The total population of women in the childbearing age in the project's catchment area is 82,073.

3) Control Of Diarrhoeal Diseases: CHW reports show 3,717 under five children who had diarrhoea out of a total under-five population of 48,202. Many community women were trained in control and management of diarrhoea at home using cereal Oral Rehydration Therapy (ORT). Women's groups, together with CHWs are also involved in community based behaviour change communication (BCC) to reduce infections that cause diarrhoea. For example, the communities constructed 130 new toilets, and 9,107 households were using water chlorination. The catchment area has a total of 77 new protected wells and boreholes.

4) HIV/AIDS Prevention: Focus group discussions have shown that a lot of people know about HIV/AIDS, although change of risky sexual behaviour appears to be slow. Most families have attributed this to the hunger situation in both districts. Some women and adolescent girls practice casual unprotected sex in exchange for food and money. HIV/AIDS awareness information was provided to community members through 6,745 brochures distributed to those who can read. Additional 96,000 people were reached through videos and films on HIV/AIDS. In the same way, Child-to-Child programs reached 13,383 community members with HIV/AIDS messages.

5) Nutrition Intervention: Malnutrition level rose from 16 – 21% in year one, and to 32% in the third year. This was attributed to the serious hunger situation in the program area. Most households eat a single meal in two days, particularly in rural areas. Nutrition intervention in the

last two years focused on working with ADRA food relief staff. We allocated maize to all thirty-two centres. This maize is ground together with soya beans and RHCs made soya porridge to feed underweight children twice per day. Women's groups and clubs also held soya-cooking classes in villages and at the RHC's. It only takes a month for a malnourished child to gain weight (enter the middle lines of the road to health card). 332 community-based cooking demonstrations on soya recipes were carried-out and a total of 17,591 received lessons (among them 998 were leaders who were very influential in effecting behaviour change within their communities).

6) Immunization Program: 12,643 out of 20,239 (62 %) children were fully immunized in the program area. On the other hand, there were 143 cases of measles reported during outbreaks due to shortage of vaccines or breakdown in cold chain. Most kerosene fridges (15) have been working well although they are old and need to be replaced with electrical or solar fridges. Also, 17,658 mothers received TT during the year.

7) Child-To-Child Intervention (CTC): Teachers and pupils take five key health messages to the community: Malaria prevention, good nutrition, HIV/AIDS prevention, diarrhoea control, and immunizations. During the year, 13,383 community members and 537 influential community leaders were reached with IEC messages. Also, 34,291 people received health education from the project through trained headmasters, teachers, and the CTC initiative.

8) Health Through Literacy Interventions: This program is not USAID funded. There was government, stakeholders and community pressure on ADRA to carryout literacy programs because 79% of women were illiterate (DIP. 1999). A small pilot project was initiated using ADRA internal funds. 31 community facilitators were trained and began teaching classes. Women especially are very excited about these classes (46% now know how to read and write and at the same time grasping health messages well). We are looking for private donors strengthen and continue this intervention.

Lastly, I would like to acknowledge the good performance of our trained community volunteers who are keen to reach-out to others despite problems of transportation and work overload. I will also take this opportunity to thank the donors – USAID Washington for funding our project. These funds have gone a long way in improving the health of children and mothers in our project area and Zambia as a whole. I'm also thankful to ADRA International senior staff for their professional backstopping and building capacity of our project staff, government personnel, and community leaders. I would like to thank the government, other international, and local partners with whom we have worked very well. For example, the Provincial Health Office, Chipata and Chadiza DHMTs; the Ministry of Education; Society for Family Health; World Vision; Social Community and Development Offices in both project districts; Care International; Plan International; Africare; Lutheran World Federation; Local District Women's Association; YWCA; and the Dorcas Society of Women). Our sincere thanks goes to the new ADRA Regional Headquarters in Randburg, South Africa. We are looking forward to a fruitful collaboration. Would like to thank ADRA Zambia Administration for their support; the Seventh-day Adventist (SDA) church, East Zambia Field; Mwami Hospital Administration and others for their support.

Lastly, I would like to thank CS XV project staff for their tireless and professional work in their respective fields of speciality.

With Kind Regards

Miriam Chipumbu, Director,
Child Survival XV Project,
ADRA, Chipata, Zambia

Acronyms and Abbreviations

ADRA	-	Adventist Development and Relief Agency
AIDS	-	Acquired Immuno-Deficiency Syndrome
BCC	-	Behaviour Change Communication
CDD	-	Control of Diarrhoeal Diseases
CHWs	-	Community Health Workers
CS	-	Child Survival
CTC	-	Child –To-Child
DHMT	-	District Health Management Team
DIP	-	Detailed Implementation Plan
DSs	-	Dorcas Societies
DWAs	-	District Women Association
EPI	-	Expanded Program of Immunization
HEALIT	-	Health through Literacy
HIV	-	Human Immuno Deficiency Virus
HIS	-	Health Information System
IEC	-	Information, Education, Communication
JGB	-	Gauf Engineers
ITNs	-	Insecticide Treated Nets
LWF	-	Lutheran World Federation
MCH	-	Maternal Child Health
MOH	-	Ministry of Health
NGO	-	Non-Governmental Organisation
NHC	-	Neighbourhood Health Committee
ORS	-	Oral Rehydration Solution
ORT	-	Oral Rehydration Therapy
OPV	-	Oral Polio Vaccine
PPAZ -	-	Planned Parenthood Association of Zambia
RHC	-	Rural Health Centre
STI	-	Sexually Transmitted Illness
TBAs	-	Traditional Birth Attendants
TOT	-	Training of Trainers
TT	-	Tetanus Toxoid
UCI	-	Universal child Immunization
USAID	-	United States Agency for International Development
VIP	-	Ventilated Improved Pit Latrines
YWCA	-	Young Women Christian Association
ZK	-	Zambian Kwacha

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Annex A: List of Names of CSXV Staff Members

Annex B: ADRA – Zambia List of Contact Persons

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ADRA/Zambia Child Survival XV Annual Project Report
October 1, 2001 – September 30, 2002

1) Introduction

The report has been arranged with a chart listing technical, capacity building, and sustainability program objectives in the first column; and an overall estimation as to whether or not there was progress towards achieving the objectives in the second column. The third column provides comments. Following is another chart listing recommendations made during mid-term evaluation and discussion of activities conducted to achieve those recommendations. Thereafter, planned activities for the year are outlined followed by discussion of constraints and recommendations for change. In addition, information utilizing data from TBAs, CHWs, CTC, Women's Groups (WGs), and Rural Health Centres (RHC) are provided.

2) Background

This is the third annual report of ADRA/Zambia Child Survival (CS) XV Project based at Mwami Hospital, Chipata, Eastern Province of Republic of Zambia. It covers the months of October 2001 to September 2002. CSXV project is an expansion from CSXI which operated from October 1995 to September 1999 in Chipata South and all Chadiza districts (it now includes the north zone of Chipata District). The project will end in September 2003.

The purpose of the report is to enable USAID, ADRA, the Zambian Government Central Board of Health (CBOH), the general public, and other stakeholders become aware of project activities and accomplishments during the year.

CSXV is operating in 32 RHCs serving a population of 444,532 with total households of 74088 (1 family: 6 members). The population served is from two ethnic groups of the Ngoni and Chewa people. The language mostly spoken is Chinyanja, though English is also widely spoken. Women have less educational and employment opportunities than men and illiteracy level for women is at 79% (Baseline survey 1999).

Most places in the program area are hilly and very remote. As a result, there is poor road network especially during rainy season. Food security was very poor during the year because farmers had limited harvest (caused by floods). Food shortage caused many deaths in the program area and some people still feed on roots or wild fruits.

3) Program Objectives and Progress Towards Objectives

See Table 1 below for program objectives and indications on progress towards achieving targets during this reporting period.

Table 1

Program Objectives	Progress toward objectives (Yes/No)	Comments
Immunizations		
Increase the % of children 12 – 23 months who are fully immunised from 73 – 77% to 80%	**Yes**	
Decrease the overall immunization dropout rate from 9 – 11% to 5%.	**Yes**	
Nutrition and Micronutrients Objectives		
Increase the % of mothers who begin giving semi-solid food to their children at age 6 months to 50%	**Yes**	
Increase the % of children aged 6 – 23 months who have received a dose of vitamin A in the last 6 months from 65% to 75%.	**Yes**	
Breastfeeding Promotion Objectives		
Increase the % of infants aged 0-6 months who are exclusively breast fed to 50%	**Yes**	
Increase the % of children aged 0 – 23 months who were breast fed within the first hour of birth to 40%.	**Yes**	
Increase the % of children aged 20-23 months who are still breast feeding to 55%.	**Yes**	
Control of Diarrhoeal Disease Objectives		
Increase the % of children < 24 months with diarrhoea in the past 2 weeks who were treated with ORS or cereal-based home ORT from 75% to 85%.	**Yes**	
Increase the % of children less than 24 months with diarrhoea in the last 2 weeks who were given the same amount or more of food during the diarrhoea from 44% to 60%.	**Yes**	
Increase the % of children less than 24 months with diarrhoea in the last 24 weeks who were given the same amount or more of food during the diarrhoea from 21% to 50%.	**Yes**	
Control of Malaria Objectives		
Increase from 78% to 85% children aged 0-23 months, with a febrile episode that were brought to a health care provider within 48 hours after the fever began.	**Yes**	
80% of CHWs will practice correct case management of malaria in children < 2 years.	**Yes**	
Increase the % of mothers with children <24 months who had at least 1 prenatal visit with a health professional to 90%.	**Yes**	
Insecticide – treated bed nets will be retreated after 6 months by 60% of purchasers.	**Yes**	
Maternal and Newborn Care Objectives		
Increase the % of mothers with children <24 months who were attended by a trained health care provider at last delivery from 48% to 60%	**Yes**	
Increase the % of women with < age 2 yr children who received 2 TT doses during the last pregnancy from 57% to 70%	**Yes**	

HIV/AIDS Prevention Objectives		
Increase the % of WRA who know 2 means of HIV/AIDS prevention to 40%.	**Yes**	
Increase the % of men who know 2 means of HIV/AIDS prevention to 30%	**Yes**	
Increase the % of youth who know 2 means of HIV/AIDS prevention to 50%.	**Yes**	
Increased community level organizational capacity Objectives		
100% of RHCs have in their catchment area a NHC, DWA, or DS member who has received TO training in a program intervention	**Yes**	
60% of NHCs, DWAs , and DSs participate in development of community health action plans	**Yes**	
70% of NHCs, DWAs, and DSs initiate a community level health education activity	**Yes**	
At least 1 Family Nutrition group functioning per RHC area	**Yes**	
70% of mothers participating in HeaLit will write a simple family health action plan	**Yes**	
Increased ADRA Zambia Organisational Capacity Objectives		
3 health proposals approved in the next 4 years (at least 2 different donors)	**Yes**	2 proposals submitted to USAID/Zambia, waiting for approval
At least 1 health program partnership formed, other than CSXV	**No**	
Inclusion of realistic objectives and action plans for health programs in Strategic Plan.	**No**	Strategic plan not conducted; plans underway through regional office (McHenry)
Increased ADRA International Organizational Capacity Objectives		
Control of Malaria interventions implemented in 2 additional countries in next 4 years.	**No**	
2 poster presentations, panel participation, and / or lecturers given by ADRA health staff at Conferences, seminars, or PVO working groups.	**Yes**	
10 articles, documents, or CS newsletters containing CS lessons learned and best practices published and externally disseminated by ADRA health staff.	**Yes**	
3 seminars, conferences, consultations, or others hosted by ADRA.	**Yes**	
ADRA CS partners meet 80% of organizational capacity targets.	**Yes**	
Sustainability Objectives		
80% of RHC staff in program catchment area completing participatory Supervision training.	**Yes**	
75% of NHCs have documented community health action plans incorporating support for CHWs / TBAs.	**Yes**	
80% of identified PHC stakeholders regularly attend quarterly meetings	**Yes**	
85% of CHWs/ TBAs report that they are supported by communities.	**Yes**	
40% increase in DWA and DS member group involved in community based CS BCC.	**Yes**	

4) Activities Following Recommendations from Midterm Evaluation

In the last quarter of year two, the project conducted a midterm evaluation and recommendations were made. During the third year, activities were conducted towards achieving those recommendations as described in Table II below.

Table II

Mid-Term Evaluation Recommendations	Activities Conducted to Help Meet Recommendations
Immunizations	
Consideration of transport in form of bicycles for CHWs to be purchased from user fees collections at the RHCs.	Project staff observed that 15 out of 32 RHCs had purchased 63 bicycles for CHWs to aid in their outreach activities
Need to strengthen the capacity of RHC Neighbourhood Health Committees (NHCs) in financial Management.	Project staff in partnership with DHMTs conducted financial management meetings for NHCs at the RHCs
There is a need to increase the supervisory capacity of RHC staff to supervise CHWs in order to achieve set immunization goals	Project staff together with the DHMTs held RHC management capacity building training to enhance their CHW supervisory skills.
There is need to replace kerosene fridges with solar fridges.	15 Kerosene fridges have not been replaced with solar fridges because of lack of funds but ADRA International sought some funds for 2 solar fridges which will be purchased soon.
There is need to train more CHWs in the project area due to its expansive nature, and as per the DIP and the MOH policy.	Additional CHWs were trained and seconded to ADRA operation areas by other NGOs like PLAN International Care International, and World Vision.
Nutrition and Micronutrients	
Consider providing demonstration, cooking utensils at the RHCs to facilitate cooking demonstrations especially with local available foods.	17 cooking pots were purchased and were distributed to 17/32 RHCs. Also, women were encouraged to use their own local utensils, and RHCs also provided utensils and food supplies to women. The project supplied women's groups with soya beans seed to plant. Some have started vegetable demonstration gardens.
Management of community malnutrition be researched and documented systematically	Mwami Adventist Hospital carried out some research on soya beans. 84 children with malnutrition were admitted and were fed on soya products and 65 of these were discharged. (19 died). The 65 children who were discharged were followed up by hospital staff and women's groups. 15 of these who had no soya were readmitted to the hospital, while those who continued on soya improved greatly.
Strengthen the monitoring and supervision of RHC staff for CHWs, TBAs and women groups in order to achieve sustainability	Project staff conducted monitoring and evaluation meetings in all RHCs. RHC staff trained volunteers who were elected democratically (CHWs/ TBAs/Women groups/NHC) in compiling and analysing monthly data.
Control of Diarrhoeal Diseases	
The DHMT in partnership with the project, follow up the issue of the controversy on the use of sugar and salt solution, with a view to harmonizing the messages communicated to the communities.	The project staff together with the Chipata DHMT held numerous meetings in order to resolve the issue of the use of sugar and salt solution and concluded that the government of Zambia had not issued any policy statement, and that use of sugar and salt solution was not mentioned in the CHW trainer's manual. Instead, the project promotes use of home-prepared cereal-based solutions as a safer alternative to ORS.
The project should explore ways of working	Project staff identified communities needing boreholes. In all

with other development partners like JBG to enhance the achievement of project objectives.	RHCs, there is a borehole. However, a total of 77 new boreholes were sunk by JBG (an Asian Company hired by the Zambian government) this reporting year.
Control of Malaria	
There is need to harmonize price of ITNs.	While there are different nets sold at different prices in the project area, the project also allowed to sell bed-nets through monitization (in kind payments of maize, groundnuts, or soya beans) and managed to sell 717 nets during the year. The issue of harmonizing costs is being addressed.
There is a need to strengthen cost-recovery initiatives of the women's groups (i.e., sell of bed nets).	The project continued to encourage women's groups to sell more nets. Reports show that women were very active in selling nets and are being given commission on each net sold (ZK 500).
There is a need for the MOH to review the malaria treatment policy to be consistent with research findings.	The treatment of malaria policy is currently under review in Zambia by the MOH. Fansidar is being promoted even on radios or televisions for the treatment of malaria (ZNBC TV 50/ 50). Also pregnant women during the first visit are given fansidar for prevention of malaria instead of chloroquine.
Health education through literacy (Health Lit) be conducted in the remaining part of the project	31 literacy facilitators were trained in the whole project area, and 775 learners were enrolled during the year. We are looking for donors to continue this initiative even past project end.
There is a need to provide bicycles, to women's groups to facilitate their movement to cover long distances.	Bicycles for women's groups have not been procured due to lack of funds.
There is a need for the project in liaison with the DHMT/RHC to provide CHWs with the basic treatment kit (for fever).	DHMTs/RHCs continue to provide basic treatment kits to CHWs/TBAs.
Maternal and Newborn Care	
Health education through literacy (Health Lit) be conducted in the remaining part of the project	31 Literacy facilitators were trained in the whole project area, and 775 learners were enrolled.
There is a need to provide bicycles, to women groups to facilitate their movement to cover long distances.	Bicycles for women groups have not been procured because of lack of funds.
There is a need for the project in liaison with the DHMT/RHC to provide CHWs with the basic treatment kits (for fever)	DHMTs / RHHCs provide basic treatment kit to CHWs / TBAs.
Explore ways and means of providing bicycles or other transport subsidies to enable the TBAs perform deliveries more efficiently and effectively.	The RHC/NHC only provide spare parts to those TBAs who have bicycles. However, the communities have constructed 61 delivery huts to prevent TBAs from travelling long distances. Also, the RHCs provide delivery kits to TBAs Meanwhile, 67 TBAs were assisted by the communities in their maize and cotton fields.
HIV/AIDS Prevention	
There is need to provide supplementary BCC materials like posters and pamphlets	In order to reinforce health messages in the communities, the project was assisted with pamphlets by other NGOs (Society for Family Health, Planned Parenthood Association, Care International) and distributed a total of 6,745 brochures. In fact, the materials were translated from English to Chewa. Those materials included information on voluntary counselling and testing. In addition, the project reached an audience of 96,000 through video films on HIV/AIDS prevention awareness during the year

Increased Community Level Organizational Capacity	
As a follow up to project interventions training, there is need to provide a joint facilitative management trainings for NHC Chairpersons, RHC in charges and treasurers of NHC for each RHC catchment area.	Project and RHC staff conducted a series of meetings and trainings to improve skills in financial management and user fee utilisation.
More training be considered for traditional healers as they have more influence on the community	The project conducted a series of meetings with traditional healers to highlight the need to refer patients to RHCs and the project repeatedly emphasised the need for awareness and prevention of HIV/AIDS.
Sustainability	
There is need for continued support and facilitative supervision from the RHC/ADRA team and DWA/DSs leadership to ensure that messages are correct and the women are motivated to continue the advocacy especially in nutrition and distribution of ITNs.	The RHCs support and supervise the women groups during cooking demonstrations in the communities and in literacy circles. Also all RHCs have formed malaria committees to ensure that ITNs are evenly distributed. This is monitored and supported by ADRA.

5) Planned Activities for the Reporting Year

a) Technical and Financial Backstopping: For the purpose of technical backstopping, the following experts from ADRA/Zambia and ADRA International visited the project during the dates indicated in the Table III below.

TABLE III

Dates	Type of Support	Name /Title
29 Oct-8 Nov 2001	Technical	Dr. Jay Edison, Director for Health, ADRA International
11-15 Mar 2002	Technical	Dr. Ron Mataya, Associate Director for Health, ADRA International
9-11 Apr 2002	Technical	Mr. R.P. Musonda, Treasurer, SDA Church, Zambia Union; Mr. Hapson Hamukali, Country Director, ADRA Zambia
23-24 Apr 2002	Monitoring	Mr Emmanuel Chigogora, Programs Director, ADRA Zambia
20-22 Jun 2002	Technical	Dr. Ron Mataya, Director for Health, ADRA International
16-22 Jun 2002	Financial	Annie Marie Stickle, Senior Finance Administrator for Health, ADRA International
21-27 Jun 2002	Finance Audit	Elwin David, and Hugo DeLeon, Internal Audits, ADRA International
16-27 2002	Financial/Audit	Mr. Lewis Chalusa, Finance Director, ADRA Zambia
12-16 Aug 2002	Proposal Writing	Mr. Emmanuel Chigogora, Programs Director, ADRA Zambia
9-10 Sep 2002	Technical	Other visitors from the headquarters and regional offices: Amy Willsey/Bureau Chief Planning, Debbie Harold/RH Advisor, Ron Mataya/ Health Advisor, Mike Negerie/Health Advisor- Regional Office, Randy Purriance/Bureau Chief, PMB

b) Project Minutes: CS XV Administrative Committee Meeting held at Mwami School of Nursing on the 10th of April 2002.

Members present:

1. Elder R.P. Musonda - Zambia Union Treasurer

2. Elder H. Hamukali - ADRA Zambia Country Director
3. Pastor L. Njoloma - Mwami District Pastor
4. Mrs. M. Chipumbu - CSXV Project Coordinator
5. Mr E. Ouso - CSXV Finance Officer
6. Mr Chizalila - Patron Mwami Hospital
7. Mr. K. Mwale - CSXV Health Information System Coordinator
8. Mr. M. Mwenitete - C S XV Immunization Coordinator

Meeting was called to order at 14.30 hours, and mainly recommended financial and administrative issues to ADRA / Zambia Board, in Lusaka.

6) Outstanding Accomplishments and Successes

The project had the following outstanding accomplishments and successes during the year:

a) Health promotion on correct practices in breastfeeding were actively conducted by 172/205 TBAs, 225/232 CHWs, 60 CTC schools, and 99/116 women's groups. The women also conducted 332 cooking demonstrations in the communities.
b) The women's groups sold 717 bed-nets and reached an audience of 17,591 with 998 community leaders during health education events in the communities.
c) The women's groups also conducted 234 demonstrations on preparation of home made ORT for diarrhoea treatment.
d) 172/205 TBAs reported and conducted 3116 successful home deliveries.
e) 225/232 CHWs reported and reached an audience of 40,913 and saw 50,066 clients.
f) CTC activities reached an audience of 13,383 and 537 community leaders through drama and poetry.
g) 31 literacy facilitators successfully completed their training.
h) The project distributed 6,745 brochures on HIV/AIDS to communities and schools.
i) 100 VIP and 30 ordinary toilets were constructed during the year in Mwami catchment area.
j) 9107 households were practising house water chlorination
k) 77 new boreholes were drilled in the whole project area.
l) 738 women of reproductive age and 37 men (775) attended health combined with literacy lessons during the year.
m) RHC/NHCs elected 2 volunteers to be compiling monthly data.
n) 97 CHWs were supported by the communities and 61 delivery huts were constructed for the TBAs.
o) 52,007 children were immunized and 17,658 women received TT.

7) Progress Towards Reaching Objectives

Below are best practices which indicated that the project made progress towards reaching objectives during the year:

a) Increased use of Soya and other traditional food stuffs, like maize; and continued education of mothers on weaning foods rich in vitamin A like paw paws, or yellow foods and protein by women groups; CHWs activities in malnutrition reduction, and treatment of diarrhoea by women's groups, etc. was evident that the project made good progress in achieving the objectives.

b) Construction and increased use of toilets, was evident enough that the community was involved in community based CS behaviour change communication
c) Increased use of bed-nets and re-treatment was a good indicator that the project was making progress towards reaching objectives.
d) Increased practice of house water chlorination and use of refuse pits indicated that the program made progress towards achieving objectives.
e) Increased access to immunisation facilities, was a good indicator that the project made good progress towards achieving the programs objectives.
f) 15/32 NHCs/RHCs bought bicycles and provided drug kits to TBAs and CHWs and this was evident that the project was making progress towards sustainability of the community volunteers.
g) Increased number of people (7796) referred to RHCs by TBAs and CHWs was indicative that the community was involved in community based CS behaviour change communication towards the knowledge and using health facilities.

8) Relativity of Project to the Work Plan

The program was relative to the work plan because the strategies used were those from the Detailed Implementation Plan (DIP). However, on the HeaLit program, the project started late because of lack of funds. Also, bed-net selling was slow (although it picked up later) due to different prices for different nets in the communities. The country was hit by hunger and this may have affected activities. Also, the country was faced with shortage of vaccines.

9) Constraints and Actions Being Taken to Overcome Them

a) A major constraint encountered during the year was hunger, where for example in Chipata district 11749 households were affected *(Flood Impact Assessment Report, May 2001, Ministry of Agriculture Food and Fisheries (MAFF)).* The hunger situation brought a negative consequence on project activities. Most people in the communities had nothing to eat and some even resorted to eating roots or wild fruits. Without food commodities, health education and cooking demonstrations was a challenge to conduct.
b) Field visits, observations, and group discussions with TBAs/CHWs/women's groups revealed that the volunteers have to walk long distances to conduct deliveries (TBAs) and health education (CHWs and women groups).
c) There are different prices for bed-nets in the program area, hence some communities are confused.
d) Demand for more mothers to enrall in literacy circles is very high and communities are requesting for more facilitators to be trained. (Chief Gawa Undi of the Chewa emphasised during the meeting at his Palace on 07 – 10 - 02)

10) Recommendations for Change

a. In order to motivate and make volunteers work well even after the life of project, it was recommended to explore ways and means for RHCs to provide them with bicycles. This will be explored further and supported by community leaders as the project comes to conclusion.
b. In order to avoid confusion in the communities in regards to costs of bed-net, it was recommended to harmonise prices in coordination with the guidelines provide by MOH.

c. In order to maintain the cold chain, it was recommended to replace kerosene fridges with solar fridges (continue to work with MOH, donors and UNICEF to get this implemented). ADRA has already procured funds to replace two of the fridges.
d. In order to empower the illiterate mothers and to have measurable achievable results on the already started literacy project, it was recommended that the literacy program be fully funded as a separate project (ADRA will identify a donor to continue and support this initiative).

11) Partnership and Collaboration Experiences

Quarterly Meetings: To discuss problems, share lessons, and coordinate/set targets with other organizations involved in CS related activities, we held quarterly meeting three times (in March, June, and September 2002) in Chipata. 105 participants attended, including Directors of Chipata/Chadiza DHMTs, representatives from PPAZ, LWF, Radio Maria, YWCA, society for Family Health, US Peace Corps, the East Zambia Field President, and Associate Director for Health from ADRA International (14-03-2002).

12) Monitoring and Evaluation

During the year the project used three techniques in monitoring and evaluation. The quarterly NGO's meeting already stated above, focus group discussions, and health care provider monthly supervision reports that follow:

a) **Focus Group Discussions**: Project staff, CHWs, TBAs, RHC staff, CTC pupils/teachers and women's groups in Chipata north, jointly conducted focus group discussions to a total of 39,407/82,073 women of reproductive age. The CHWs led out the discussions and the women discussed questions in small groups of 5 to 6 participants. The women answered well and actively with openness especially on HIV/AIDS prevention.

b) **Health care providers monthly supervision reports**: The program staff visited each RHC in the program area 12 times during the year. They monitored output process of volunteers, communities, and collected monthly data. Then the HIS office analysed, interpreted, and shared the data as indicated in the following tables (Tables 4.1 to Table 4.9):

Table 4.1
Traditional Birth Attendants Annual Report

Number of Centres Reporting	32/32
Number of TBAs Trained	205
Number of TBAs Reporting	172
% of TBAs Reporting	84%

# of RHCs	Deliveries	Antenatal	Home Deliveries	Eye Drops	Mothers well	Babies well			Still Births		Referred to hospital	Abortion	# of postnatal attended to	VA given
						F	M	Total	F	M				
32/32	3137	3067	3137	124	3137	1580	1530	3110	2	10	289	33	2683	2901
Total									**12**					

Additional statistics
Number of maternal deaths: **None**
Total number of participants at health talks: **2177**

From the above data, there were **3137** home deliveries conducted by TBAs, **3067** women attended antenatal care, and **3137** mothers were well at postnatal check-up because TBAs were practicing hygienic measures when conducting deliveries. However, the report also revealed that there were **12** stillbirths caused by prematurity, breech presentation, and prolonged labour. The ages of stillbirth's mothers were 17, 19, 26, 35 and 37. And 84**% (172/205)** of the TBAs reported during the year.

Table 4.2
Community Health Workers Annual Report

Number of RHCs Reporting	**32 / 32**
Number of CHWs Trained	**232**
Number of CHWs Reporting	**225**
% of CHWs Reporting	**97%**
Total Catchment Population*	**399,517**

*Catchment population varies according to CHWs who report during that year.

Additional statistics
Number of male births during the year: **1428**
Number of female births during the year: **1233**
Total live births during the year: **2661**
Males born dead: **17**
Female born dead: **24**
Total born dead: **41**
Total births during the year, including those born dead: **2702**

Number of <5 male deaths during the year: **186**
Number of <5 female deaths during the year: **112**
Total number of <5 deaths during the year: **298**

Number of >5 male deaths during the year: **169**
Number of >5 female deaths during the year: **140**
Total number of >5 deaths during the year: **309.**

Total deaths during the year (both categories listed above): **607**

Number of patients/clients seen during the year: **50,066**
Maternal death: **0**
Abortions: **6**

Table 4.3
Morbidity (Illness) Statistics

Disease	Age Group		Total	Referrals
	<5 Years	>5 Years		
Malaria	8814	1165	9979	2097
Diarrhoea	3717	2730	6447	927
Acute respirator cases	1495	1708	3203	681
Malnutrition	1350	220	1670	663
Injury	445	464	909	477
Confirmed tuberculosis cases	31	119	150	28
Sexually transmitted diseases	None	310	310	310
Other diseases	3190	5641	8831	2324
Total	**19,042**	**12,357**	**31,499**	**7507**

Additional Statistics on Health Education
Number of health education sessions held: **1235**
Total male participants at health education sessions: **16153**
Total female participants at health education sessions: **24760**
Total male and female participants during health education sessions**: 40913**

Household use of mosquito nets: **26,642**
Households practicing water chlorination methods: **9,107**
Number of neighbourhood health committees meetings held: **156**
Total participants at NHC meetings: **108,647**
Number of CHWs supported by NHCs: **97**

Table 4.4
Child-To-Child Teachers Annual Report

# of RHCs	Total Schools	# of Schools Reported	% of Schools Reported	School Health Education		Out of Classroom Health Education			# of Education Clubs
				Events	Students	Events	People	Leaders	
32/32	**112**	**60**	**53.6%**	**413**	**34291**	**161**	**13,383**	**537**	**58**

The data presented above indicates that **161** out of classroom CTC health education activities were held, an audience of **13,383** people, and **537** community leaders were reached. In addition, school health educators conducted **413** educational events reaching **34291** pupils with health messages during the year.

Table 4.5
Women's Group Annual Report

Number of Centres Reporting	**32/32**
Number of Women Trained	**116**
Number of Women Reporting	**99**
% of Women Reporting	**85%**

Health Education / Health Promotion

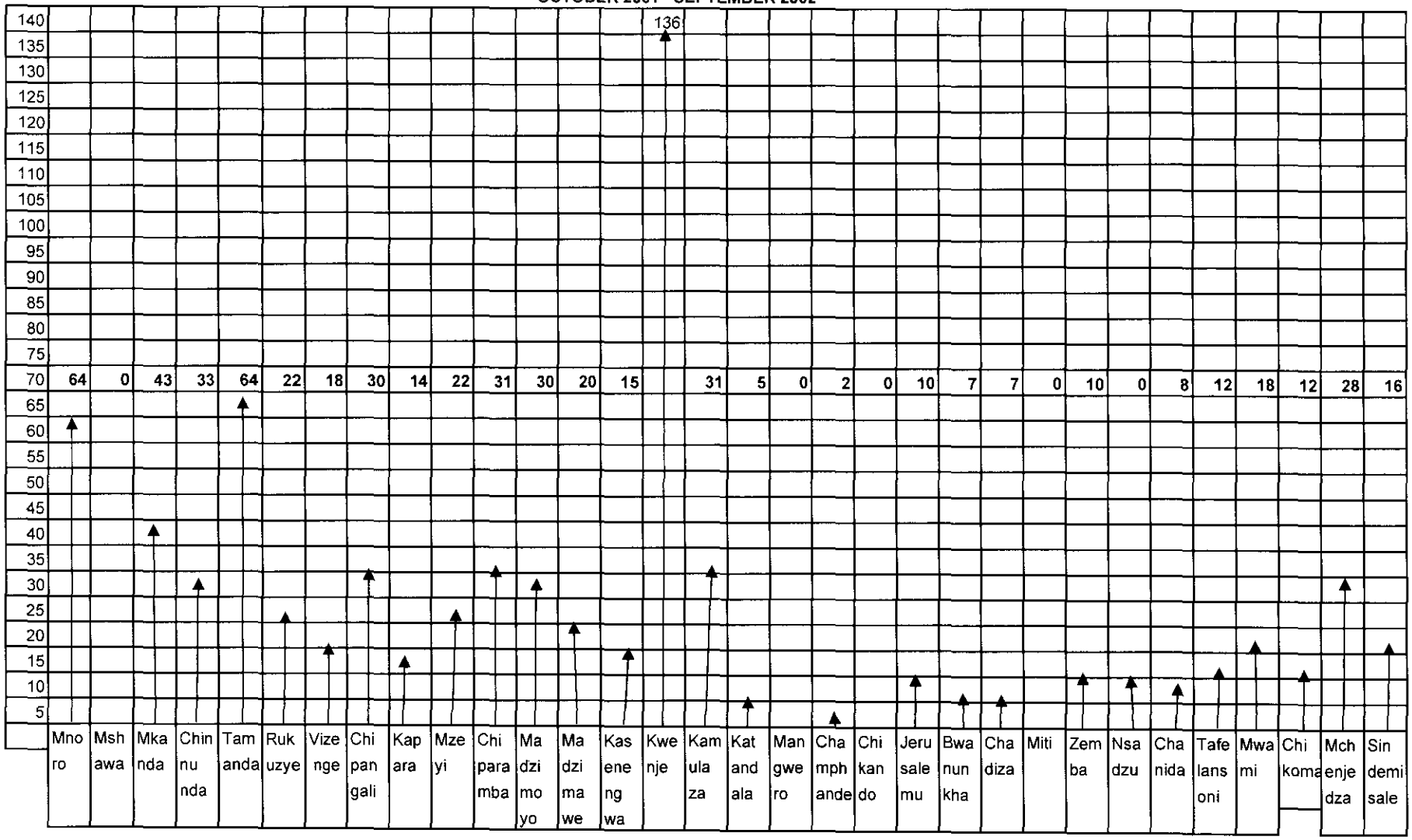
Events	Type of Group	No. of Cooking Demonstrations	No. of Functioning Women's Groups	Total No. of People	No. of Leaders	Topics
197	Dorcas Societies (DSs)	**182**	**68**	**8317**	**451**	**Malaria control, nutrition cooking demonstrations and control of diarrhoea diseases**
200	District Women's Association (DWAs)	**150**	**70**	**9274**	**547**	
397		**332**	**138**	**17,591**	**998**	

Statistics on Malaria Prevention by women's groups
Number of nets sold: **717**
Number of nets retreated after six months: **477**

From the data above, through **397** educational events, women's groups reached an audience of **17,591** people and **998** community leaders. There were **138** functioning women's groups in the program area and **332** cooking demonstrations were conducted in various localities of the communities. Women's groups also sold **717** bed-nets and re-treated **477** after a period of 6 months.

CHIPATA AND CHADIZA DISTRICTS MOSQUITO NET ANNUAL SALES

OCTOBER 2001 - SEPTEMBER 2002



From the data shown above it revealed that 717 nets were sold during the year. Kwenje RHC of Chipata North sold the highest while Mshawa, Magwero, Chikando, Miti and Nsadzu sol

Growth Monitoring

Data for growth monitoring was collected from 32 RHCs in the whole program area, which included numbers of children weighed and numbers of growth faltering children as tabulated below:

Table 4.6
Nutrition Improvement Annual Report
Children Not Gaining Weight

	0 – 11 Months			12 – 23 Months		
Number of RHCs	Total Seen	Below Lower Line	Percent Below Lower line	Total Seen	Below Lower Line	Percent Below Lower Line
32/32	**39,497**	**7215**	**18.3%**	**35,308**	**11,642**	**32.9%**

From the data above, **18.3%** of the children under one year were underweight, while those in their second year demonstrated a higher malnutrition rate **(32.9%).** The difference was due to a serious hunger situation in the program area. Most households had nothing to eat.

Vitamin A Supplementation

Vitamin A data was collected from the 32 RHCs as tabulated below:

Table 4.7
Vitamin (A) Annual Report

	Vitamin A Administered during the Quarter		
Number of RHCs	6 – 11 months	12 – 59 months	Total
32/32	**8248**	**35,488**	**43,736**

From the data shown above, 43,736 vitamin A capsules were administered in accordance with WHO/MOH protocol during the year.

Table 4.8
Universal Child Immunization (UCI)

Vaccine	< 1 Year	Fully Immunized	Total Target Population
BCG DPT 3 OPV 3 Measles	10,410 12,874 13,701 15,022		
		15, 022	**20,239**
TT	**17,658** (for pregnant women)		

From the data shown above, 74% (15,022 / 20,239) children were fully immunized in the whole program area. Also 17,658 mothers received TT. Immunization coverage was low because there were shortages of DPT, Polio and BCG vaccines and kerosene fridges were often broken down in the RHCs. As a result, there were 143 cases of measles admitted at Mwami Hospital and all were discharged.

Table 4.9
Health through Literacy Reflect Annual Report

Number of centres reporting	31/32
Number of centres (facilitators) Trained	31/32
% of facilitators reporting	100%

Total number participants enrolled	Male Female Total	**37** **738** **775**
Total number of dropouts and followed up		**47**
Total number of participants:	Genuine Lapsed	**501** **274**
% of participants who were able to read and understand a paragraph (471 x 100/775)		**60%**
% of participants who were able to write a letter with clear handwriting (463 x 100/775)		**59.7%**
% of participants who were able to compute in written form the four basic numeracy functions with numbers up to four figures (398 x 100/775)		**51%**
% of participants who were able o write their own family health action plan (358 x 100/775)		**46.2%**
% of participants who attended all the hours in the year (567 x 100/775)		**73%**

From the data above, 31 RHC staff were trained, **31** facilitators reported, and **775** participants enrolled during the year. Among those enrolled, **37** were male while **738** were female mostly of reproductive age. Out of total participants, **501** were genuine (those who had not entered school before) while **274** were lapsed (those who had started school but dropped in lower grades). The data further revealed that **60% (471 x 100/775)** of the participants were able to read and understand a paragraph while **59.7%** were able to write a letter with clear handwriting and **73% (567/775)** attended all the planned literacy training hours during the year.

13) Plans for Next Reporting Year

a) The EPI coordinator will visit all RHCs to promote immunization programs.
b) The nutrition coordinator will go round in all RHCs catchment area villages to intensify cooking demonstrations and will promote breastfeeding.
c) Training of women groups in those RHCs which are not selling nets will also be conducted at RHC level.
d) The CDD coordinator will visit all RHCs to promote home made cereal solution for diarrhoea treatment.
e) The malaria coordinator and women groups will intensify the selling of bed-nets in the whole project area.
f) Maternal and Newborn care, the MCH coordinator will visit all RHCs to encourage TBAs to continued reporting after the life span of the project.
g) HIV/AIDS prevention, coordinator will visit all RHCs and communities to promote HIV/AIDS awareness activities.
h) Strengthen HIS department
i) The program staff will conduct focus group discussions in all RHCs villages and all CTC schools
j) The project will conduct quarterly report meetings with other NGOs and GRZ partner ministries.
k) The project will visit all RHCs for data collection from volunteers which will include HeaLit programs.

l) The project will conduct final evaluation in the fourth quarter of year four, to measure the whole worthiness of the program.

14) Conclusion

In conclusion, the CSXV programs for year three were successful in that 225 out of 232 CHWs; 172 out of 205 TBAs; 60 out of 112 CTC schools; and 99 out of 116 women groups reported during the year.

Moreover, women's groups sold 717 bed-nets and reached on audience of 17,591. Major constraints were shortages of vaccines in RHCs and frequent breakdown of kerosene fridges which increased the percentages of dropout rates. Also the Healit Program is on very high demand in the communities while it has no full funding. On the whole, the programs were on target and project staff worked very hard. Meanwhile, the communities were appreciating ADRA International and USAID for implementing the project in the area and may God add more wisdom and blessings to all stakeholders.

Annex A: List of Names of CSXV Members of Staff

S/No.	Name	Position
1.	Miriam Chipumbu	Project Director
2.	Eric Ouso	Project Finance Officer
3.	Kazembe Mwale	Training and Health Information System Coordinator
4.	Doreen Daka	Malaria and Maternal and Child Health Coordinator
5.	Elizabeth Njoloma	Nutrition Coordinator
6.	Charles Mtine	HIV/AIDS Coordinator
7.	Maxwell Mwenitete	Immunization Coordinator
8.	Masauso Mhlanga	Control of Diarrhoeal Diseases Coordinator
9.	Wilfred Banda	Child – to – Child Coordinator
10.	Mary C. Phiri	Secretary
11.	Clara Chiyengo	Clerk / Logistics
12.	Milica Soko	Bookkeeper
13.	Josen Jere	Driver
14.	Anikazio Zulu	Driver
15.	Winston Banda	Guard
16.	Bedford Phiri	Guard
17.	Stephen Njobvu	Guard
18.	Elizabeth Phiri	Custodian

Annex B: ADRA Zambia List of Contact Persons

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Annex C: Training Reports On In Charges

One Day Workshop for Chipata North Rural Health Centres Staff In-charges Held at AIEMS Resource Centre in Chipata on 18th May, 2000.

18 Rural Health Centre Staff attended the workshop.
15 Rural Health Centres except one were represented.

The rural Health Centres In-charges were given reports on the trainings which were conducted at Kalichelo. Also Mr. Square the Director for Eastern Province Health management Team informed the In-charges to work well with the community based caretakers. Mr. Square also urged the In-charges to be accountable to the community and encouraged income generation activities so as to generate Neighbourhood Health Committee finances to support Traditional Birth Attendants and Community Health workers. Mr. Square finally informed the in-charges to emulate ADRA CSXV system of good coordination with Chiefs.

One Day Workshop for Chipata North Midwives Held at AIEMS Resource Centre in Chipata on 26th May 2000.

15 Midwives attended from 15 Rural Health Centres except one Rural Health Centre. The midwives workshop was more like that one for the Rural Health Centre In – charges except that they were directly informed to coordinate the women groups and Traditional Birth attendants.

Annex D: Minutes for the Community Monitoring Meeting held at Katandala RHC

Date: 17th September 2002

MEMBERS PRESENT:

2 Nurses from Katandala RHC
1 Chairman for NHC – Mr Mark Tembo
25 NHC members
3 active CHW (2 are inactive)
2 Trained TBAs (1 trained – not active)
4 Untrained TBAs
2 Women group (Literacy facilitator) 3 trained inactive women groups
1 Youth Friendly Coordinator
1 Deputy headmistress – Mrs Philomena Banda from Katandala Middle Basic School
1 Child-to-child Teacher – Mr Thomas Jere from Katandala Middle Basic
10 Literacy students

APOLOGIES

From Child-to-Child teachers at Sanjika Middle Basic school.

AGENDA AND MEETING

Meeting opened at 09.00 hours with a prayer .

Drama, poems and Health Education was conducted by Child-to-child pupils from Katandala Middle Basic.

Opening speech was given by Mrs M. Chipumbu – ADRA Project Coordinator.

Immunization play was given by Adult Literacy students from Katandala Kamshana Bango Adult Literacy School. After that there was a separate meeting with the volunteers.

NHC GROUP

It was active and holding meeting regularly. They took part in the Immunization week this month. The NHC was reminded of its duties in planning for health Interventions in Katandala catchment area and that they were to spearhead and guide the community on volunteer remunerations in form of in-kind giving and helping the volunteers with field tasks. To get donations of Soybeans grounds and beans and maize, so that the women who will be trained in Nutrition will have a beginning for their Cooking Demonstrations

CHWs

There are three active CHWs two are inactive. The NHC and CHWs were encouraged to involve the inactive CHWs in their programs so that they can become active again.

Mr. Mwanza – a CHW from Lopo village was chosen as Data Supervisor, who will be in charge of compiling data of all the volunteers. Mr Chulu, an NHC member and Youth Friendly Coordinator, will be the Assistant Data Supervisor. To discuss ADRA Chewa questionnaire to all members of the NHC who will also disseminate the information to others

Mr. K. Mwale – ADRA HIS – to go and give training on how to compile data.

TBAs

There are 3 trained TBAs out of which 1 is not active. There are also 4 untrained TBAs working hand in hand with RHC staff and trained TBAs.
The centre gives TBAs vitamin A capsules to give to women they deliver and eye ointment drops to instil in New born babies eyes.
The new report form has no provision for recording number of women who received vitamin A. Mr K. Mwale – ADRA HIS to look into the problem. There is need for NHC to consider constructing TBA huts for delivering women.

Women Groups (DS and DWA)

There's only 1 trained women group and she's at the same time trained as Literacy facilitator. The three other women who were trained have been inactive. There's need for the neighbourhood to choose four different women who will receive training from ADRA. ADRA promised to get in touch with them concerning training of the four women.

LITERACY ADULT CLASSES.

There's 1 trained facilitator- the women in nearby villages are interested in beginning the class 87 women have shown great interest in learning. ADRA advised her to have a class of not easy for her to teach ADRA may train another teacher later on upon getting funds.

Katandala catchment area.

Katandala catchment area has a population of 7,000 people. The big villages around Katandala are: Kaluba, Mashanga, Mgabi, Shabati, Lopo, Moneni and Ngocho.

It was agreed that the 3 CHWs with the help of women group, will continue giving health education in all of these villages. The CHWs will also use ICI zones to meet people there for Health Education

The meeting finished at 13.30 hours - closing prayer by Mr Mwanza- (CHW).

Annex E
CHW weighing a child at Maulabo village in Mwami Catchment area.

Women groups/Dorcas societies conducting soya recipe cooking demonstrations at Chipangali RHC using Local resources

Annex E

Participants were conducting an exercise of drawing a tree during the post-mortem of the field trip with Mr Kazembe Mwale the HIS/Literacy co-ordinator facilitating the lesson at Musipazi Parish