ザンビア共和国
ルサカ市プライマリーヘルスケアプロジェクト
（フェーズ２）
実施協議報告書

平成17年２月
（2005年）

独立行政法人　国際協力機構
人間開発部

序　　文

ザンビア共和国の首都であるルサカ市及び周辺地域では急激な人口増加が進み、住民が劣悪な環境下で生活するなか、保健医療及び環境衛生の改善、強化が緊急の課題となっています。そのような状況のなか、国際協力事業団（当時）（JICA）は、1997年３月から2002年３月までプロジェクト方式技術協力「ルサカ市プライマリーヘルスケアプロジェクト」を実施することにより、ルサカ市の未計画居住区の一つであるジョージ地区において、住民組織とヘルスセンター職員による事業運営体制の確立、子供の成長促進活動及び水・環境衛生に関する活動が行った結果、コレラ感染者の減少、コミュニティーヘルスワーカーの増加とそれに伴う子供の定期健診、予防接種等の自立的な運営など多くの成果が確認されました。

ザンビア政府はこの成果を受け、活動を他地区にも拡大する新規プロジェクトを日本政府に対し要請しました。右要請を受け、JICAは各種調査の結果、フェーズ１で対象としたジョージ地区に加え、他５地区（カニャマ、ムテンデレ、チパタ、チャワマ、ンゴンベ）を対象とし、更にプロジェクトの自立発展性の観点から、行政側からの恒常的かつ組織的なサポートを得ることを念頭に置き、コミュニティーと保健行政組織との間を機能的にリンクされるプロジェクト（フェーズ２）として、2002年７月から５年間の予定でプロジェクトを開始することとしました。

プロジェクトの開始するに際しては、2002年６月23日から７月１日までの日程で国内委員長である国際医療福祉大学大学院 梅内拓生教授を団長とする実施協議調査団を派遣し、本報告書はその調査結果を取りまとめたものです。

ここに、本調査にあたりご協力を賜りました関係各位に対しまして深甚なる謝意を表しますとともに、プロジェクトの実施・運営にあたり、引き続き更なるご協力をお願いする次第です。

平成17年２月

独立行政法人国際協力機構
人間開発部長　末森　満

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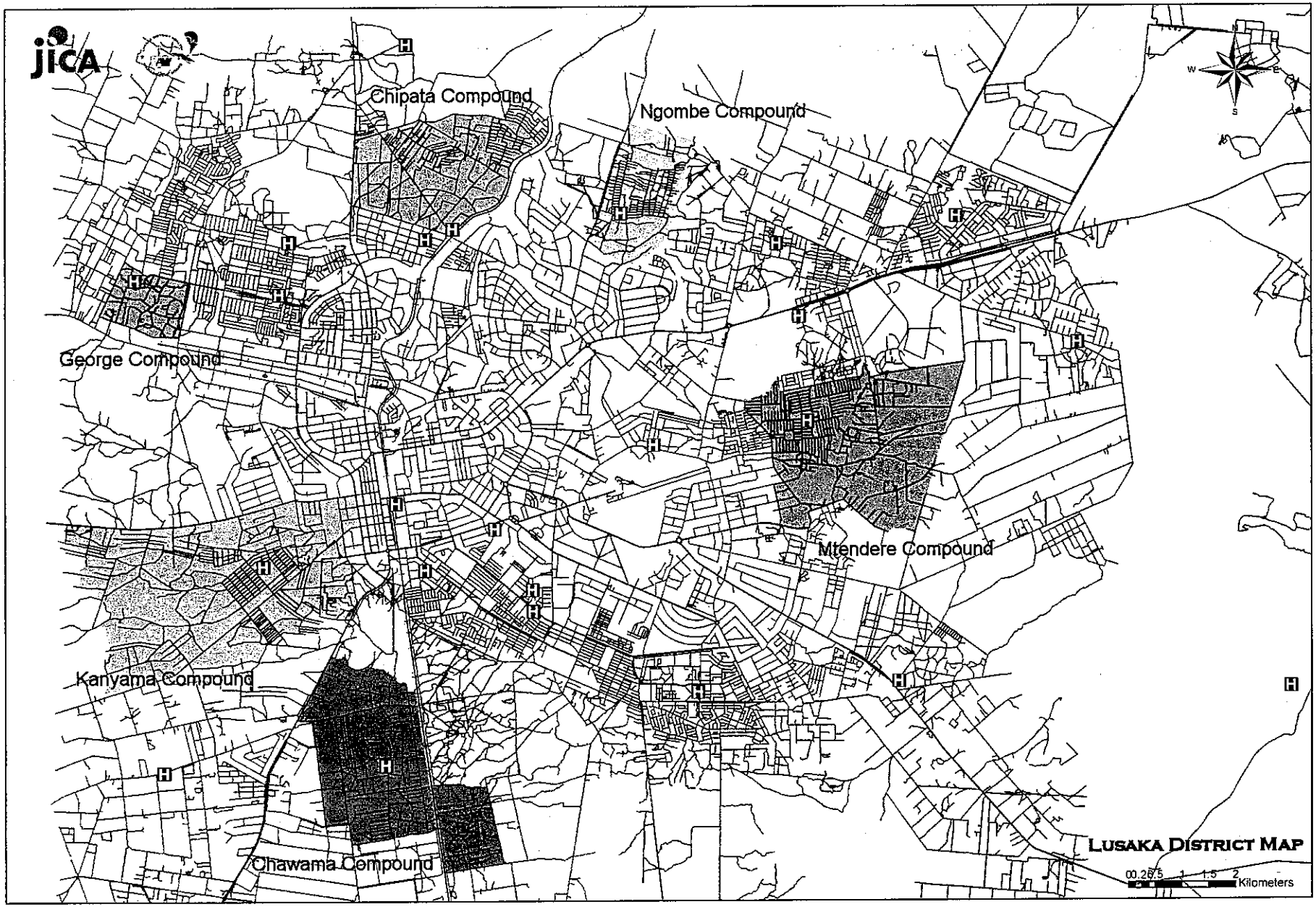
略 語 表

CBoH	Central Board of Health	保健省中央保健総局
GMP	Growth Monitoring Program	（子供の）成長モニタリング
JICA	Japan International Cooperation Agency	国際協力機構
MoFNP	Ministry of Finance, National Planning	財務国家計画省
LDHMT	Lusaka District Health Management Team	ルサカ市保健管理局
NFNC	National Food and Nutrition Committee	国家食糧栄養委員会
PDM	Project Design Matrix	プロジェクト・デザイン・マトリックス
R／D	Record of Discussion	協議議事録
ZIHP	Zambian Integration of Health Planning	ザンビア統合保健プログラム


JICA
Chipata Compound
Ngombe Compound
George Compound
Mtendere Compound
Kanyama Compound
Chawama Compound
LUSAKA DISTRICT MAP
0 0.25 0.5 1 1.5 2
Kilometers

第１章　調査の概要

１－１　調査団員

担　当	氏　名	所属・役職
総　括	梅内　拓生	国際医療福祉大学大学院教授 国際部長
公衆衛生	鈴木　宏	新潟大学大学院医歯学総合研究科国際感染医学講座公衆衛生学分野 教授
NGO連携	菅波　茂	アジア医師連絡協議会（AMDA）　代表
協力計画	奥本　恵世	国際協力事業団医療協力部医療協力第二課 職員

１－２　調査日程

調査期間：2002年６月24日～29日

日　時	用務内容
６月24日	ルサカ着、日本大使館表敬、JICA事務所打合せ
６月25日	ルサカ市保健管理局（LDHMT）訪問、財務国家計画省（MoFNP）表敬、保健省中央保健総局（CBoH）表敬
６月26日	LDHMTと協議、ザンビア統合保健プログラム（ZIHP）訪問
６月27日	国家食糧栄養委員会（NFNC）訪問、プロジェクト合同調整委員会メンバー（予定）との協議
６月28日	R／D、M／M署名、在ザンビア日本大使館及びJICAザンビア事務所報告、団長主催レセプション
６月29日	ルサカ発

１－３　ザンビア側主要面談者

(1) 保健省

事務次官	Dr.Simon K.MITI
開発計画局長代理	Dr. Dares M.CHIMFWEMBE
ドナー調整官	Grace MAKAYI

(2) ルサカ市保健管理局

局　長	Dr. Moses SINKALA
開発計画課長	Dr. M. Makasa CHIKOYA
開発計画課長	Dr. Clara Mbwili MULEYA
医薬品調達担当	Constantine MALAMA
学校保健サービス担当	Derrick K.M'PAKA
臨床ケア専門官	Armakungu KABASO
看護官	Mary BANDA

(3) 財務国家計画省

二国間協力担当	A. MUSUNGA

(4) ルサカ市役所

公衆衛生・社会サービス局長補佐	Misheck H.ZYUULU
栄養サービス担当官	Maris E.M.KALUMBA

(5) ジョージ地区ヘルスセンター

環境衛生委員	Nixon TEMBO
環境衛生委員	Tamara L.MWAMULOWE
母子保健担当	Evelin TEMBO

(6) カニャマ地区ヘルスセンター

栄養士	Emily Zulu MALESH

(7) チャワマ地区ヘルスセンター

栄養士	Kabso KABWE
環境衛生委員	Mildred L.M.KANYENGE

(8) 国家食糧栄養委員会

委員長代理	Freddie MUBANGA
栄養士	Chisela KALIUELE

1－4　調査結果

短期調査の結果に基づき、ザンビア側関係者とプロジェクト実施体制、活動内容、外部条件などにかかる協議を行うとともに、結果をR／D及びミニッツ（付属資料１及び２のとおり）に取りまとめ、署名した。

合意されたプロジェクト概要は以下のとおりである。

(1) プロジェクト名

英　語：Lusaka District Primary Health Care Project Phase II

日本語：ルサカ市プライマリーヘルスケアプロジェクト（フェーズ２）

(2) マスタープラン

1) 上位目標

ルサカ市の５歳未満の子供の健康状態が改善する。

2) プロジェクト目標

選ばれたヘルスセンター管轄地区の５歳未満の子供の健康状態が改善する。

3) 成果：① コミュニティーベースの子供の成長促進活動が強化される。

② コミュニティーの環境衛生サービスが改善される。

③ ５歳未満の子供に対する病気の特定能力とコミュニティーのリファラル活動が改善される。

④ ルサカ市保健管理局（LDHMT）のヘルスセンター及び住民組織に対する支援

能力が強化される。

(3) プロジェクト期間

2002年７月15日から５年間

１－５　協議結果

(1) プロジェクト内容

短期調査の結果（付属資料３のとおり）、並びにその後単発専門家として派遣された佐々木論専門家（プライマリーヘルスケア）及び五十嵐久美子専門家（健康教育）による活動計画案（付属資料４のとおり）により、プロジェクトの大まかな内容は合意されていたが、今次調査において一部修正が行われ、最終的な合意に至った。

当面の活動としては、世帯調査の実施と乳幼児の登録、フェーズ１に引き続いた子供の成長促進活動タスクフォースの設置と着実な実施、ジョージ地区での環境衛生活動の自立発展のための活動と他地区への普及に向けた環境衛生ガイドラインの作成、コミュニティーリファラルタスクフォースの設置が実施される予定である。

(2) 実施体制

フェーズ１と同様、保健省事務次官をプロジェクト・ダイレクター、ルサカ市保健管理局局長をプロジェクト・マネージャーとすることで合意した。事務次官は今次調査の前週に着任したばかりであるが、フェーズ１実施時には中央保健総局の長官としてプロジェクトに関わっており、大きな影響はないと思われる。

合同調整委員会については、保健省、中央保健総局、ルサカ市保健管理局、ルサカ市役所、財務国家計画省他のメンバーで構成されることが確認され、調査団滞在中にもプレ合同調整委員会が行われた。プロジェクト開始後は半年に１度開催するとともに、プロジェクト進捗モニタリング報告書の作成も、その役割として位置づけられた。

(3) ザンビア側関係機関との協議

ザンビア統合保健プログラム（ZIHP）、国家食糧栄養委員会（NFNC）と訪問した。ZIHPはUSAIDの実施しているプログラムであるが、85名ほどのスタッフを雇用し独自に事業を実施している。ZIHPは保健政策へのサポートを活動の大きな柱の一つとしており、今後保健行政レベルへの関与を深めていく必要があるフェーズ２としても今後協力していく必要のある相手であることが確認された。

NFNCは保健省の下部組織にあたる委員会であり、特に子供の成長促進活動（GMP）について、フェーズ２でも密接に関わっていく必要がある。調査団よりプロジェクト内容の説明を行ったところ、NFNCはコミュニティーをベースにしたGMPのクオリティ・コントロール、技術指導、トレーニング等を行っており、フェーズ２と重なる部分も多く、今後協力していきたいとの発言を得た（既にNFNCはGMPに関するタスクフォースを組織している）。

(4) 地理的情報システム（GIS）の導入

GISを導入することにより、正確な記録が得られ、疫学的分析に役立つというメリットはあ

るものの、①スタッフが使いこなすことが可能か、②導入コストに対してどの程度の効果があるか、等を見極める必要がある。今後プロジェクト開始後にGIS導入計画がプロポーザルとして提出された場合は、導入に係るコストと効果を検討した上で決定することとした。

第２章　団長所感

今回の調査では、プロジェクト目標を達成するための成果として４項目〔第１章１－４の(2)参照〕についてザンビア側と合意したが、それらはすべてキャパシティ・ビルディングに関連することである。

保健省も、上記成果を得ることによりプロジェクト目標を達成するには、省内の各部局間の協力だけでなく、他組織、省庁間との協力を通じ、ザンビア政府が一丸となって本プロジェクトを支援することが重要である旨言明しており、忠実な遂行が望まれる。

同時にプロジェクトの開始後は、日本側も母子保健分野の協力と環境衛生改善のための協力に重点を置きつつ、ザンビア側と定期的に合同調整委員会を開催して、一層緊密に協力することを期待したい。

付　属　資　料

1．協議議事録（R／D）

2．調査団議事録（Minutes of Meeting）及びプロジェクト・ドキュメント

3．短期調査（2002年１月23日～2002年３月４日）結果

4．活動計画案

RECORD OF DISCUSSIONS
BETWEEN THE JAPANESE IMPLEMENTATION STUDY TEAM AND THE MINISTRY OF HEALTH OF THE GOVERNMENT OF THE REPUBLIC OF ZAMBIA ON JAPANESE TECHNICAL COOPERATION FOR THE LUSAKA DISTRICT PRIMARY HEALTHCARE PROJECT PHASE II

The Japanese Implementation Study Team (hereinafter referred to as "the Team") organized by the Japan International Cooperation Agency (hereinafter referred to as "JICA") visited the Republic of Zambia from 24 June, 2002 to 29 June, 2002 for the purpose of working out the details of the technical cooperation program concerning the Lusaka district primary healthcare project phase II.

During its stay in Zambia, the Team exchanged views and had a series of discussions with the Zambian authorities concerned with respect to desirable measures to be taken by both Japanese and Zambian Governments for the successful implementation of the above-mentioned Project.

As a result of the discussions, the Team and the Zambian Ministry of Health agreed to recommend to their respective Governments the matters referred to in the document attached hereto.

Lusaka, Zambia, 28 June, 2002

Prof. Takusei Umenai
Leader,
Japanese Implementation Study Team,
Japan International Cooperation Agency,
Japan

Dr. Simon. K.Miti.
Permanent Secretary,
Ministry of Health,
The Republic of Zambia

Witnessed by: A. Musunga

Ms. A. Musunga
Chief Economist, Bilateral Cooperation,
Department of External Resources Mobilization,
Ministry of Finance and National Planning,
The Republic of Zambia

THE ATTACHED DOCUMENT

I. COOPERATION BETWEEN BOTH GOVERNMENTS

1. The Government of the Republic of Zambia will implement the Lusaka District Primary Health Care Project Phase II (hereinafter referred to as "the Project") in cooperation with the Government of Japan.

2. The Project will be implemented in accordance with the Master Plan which is given in Annex I.

II. MEASURES TO BE TAKEN BY THE GOVERNMENT OF JAPAN

In accordance with the laws and regulations in force in Japan, the Government of Japan will take, at its own expense, the following measures through JICA according to the normal procedures of Japanese technical cooperation scheme of Japan.

(1) DISPATCH OF JAPANESE EXPERTS

The Government of Japan will provide the services of Japanese experts as listed in Annex II.

(2) PROVISION OF MACHINERY AND EQUIPMENT

The Government of Japan will provide such machinery, equipment and other materials (hereinafter referred to as "the Equipment") necessary for the implementation of the Project as listed in Annex III. The Equipment will become the property of the Government of the Republic of Zambia upon being delivered C.I.F. (cost, insurance and freight) to the Zambian authorities concerned at the ports and/or airports of disembarkation.

(3) TRAINING OF THE ZAMBIAN PERSONNEL IN JAPAN

The Government of Japan will receive Zambian personnel connected with the Project for technical training in Japan.

(4) SPECIAL MEASURES FOR TRAINING OF MIDDLE-LEVEL MANPOWER

The Government of Japan will Supplement a portion of the following local expenditures, necessary for the training programmes for middle-level manpower conducted in the

Republic of Zambia.

1) Traveling allowances for the training participants between their assigned places and the site of the training.
2) Cost of the production of teaching materials.
3) Travel costs of the training participants for their field trips.
4) Cost of procurement of supplies and equipment necessary for the training programs.
5) Travel allowances of the local instructors of the training programs accompanying the trainees on their field trips.
6) Remuneration of the instructors invited from institutions other than those directly connected with the Project.

Japanese funding for the above-mentioned expenses will be reduced annually. The reduction of the Japanese funding will be compensated by additional Zambian funding.

III. MEASURES TO BE TAKEN BY THE GOVERNMENT OF THE REPUBLIC OF ZAMBIA

1. The Government of the Republic of Zambia will take necessary measures to ensure that the self-reliant operation of the Project will be sustained during and after the period of Japanese technical cooperation, through full and active involvement in the Project by all related authorities, beneficiary groups and institutions.

2. The Government of the Republic of Zambia will ensure that the technologies and knowledge acquired by the Zambian nationals as a result of Japanese technical cooperation will contribute to the economic and social development of the Republic of Zambia.

3. The Government of the Republic of Zambia will grant in the Republic of Zambia, privileges, exemptions and benefits as listed in Annex IV and will grant privileges, exemptions and benefits no less favorable than those granted to experts of third countries or international organizations performing similar missions to the Japanese experts referred to in II-1 above and their families.

4. The Government of the Republic of Zambia will ensure that the Equipment referred to in II-2 above will be utilized effectively for the implementation of the Project in consultation with the Japanese experts referred to in Annex II.

5. The Government of the Republic of Zambia will take necessary measures to ensure that the knowledge and experience acquired by the Zambian personnel from technical training in Japan will be utilized effectively in the implementation of the Project.

6. In accordance with the laws and regulations in force in the Republic of Zambia, the Government of the Republic of Zambia will take necessary measures to provide at its own expense:

(1) Services of the Zambian counterpart personnel and administrative personnel as listed in Annex V;

(2) Land, buildings and facilities as listed in Annex VI;

(3) Supply or replacement of machinery, equipment, instruments, vehicles, tools, spare parts and any other materials necessary for the implementation of the Project other than the Equipment provided through JICA under II-2 above;

(4) Means of transport and travel allowances for the Japanese experts for official travel within the Republic of Zambia ; and

(5) Suitably furnished accommodation for the Japanese experts and their families.

7. In accordance with the laws and regulations in force in the Republic of Zambia, the Government of the Republic of Zambia will take necessary measures to meet:

(1) Expenses necessary for transportation within the Republic of Zambia of the Equipment referred to in II-2 above as well as for the installation, operation and maintenance thereof;

(2) Customs duties, internal taxes and any other charges, imposed in the Republic of Zambia on the Equipment referred to in II-2 above; and

(3) Running expenses necessary for the implementation of the Project.

IV. ADMINISTRATION OF THE PROJECT

1. The Permanent Secretary for the Ministry of Health, as the Project Director, will bear overall responsibility for the administration and implementation of the Project.

2. The Director of Lusaka District Health Management Team, as the Project Manager, will be responsible for the managerial and technical matters of the Project.

3. The Japanese Chief Advisor will provide necessary recommendations and advice to the Project Director and the Project Manager on any matters pertaining to the implementation of the Project.

4. The Japanese experts will give necessary technical guidance and advice to the Zambian counterpart personnel on technical matters pertaining to the implementation of the Project.

5. For the effective and successful implementation of technical cooperation for the Project, a Joint Coordinating Committee will be established whose functions and composition are described in Annex VII.

V. JOINT EVALUATION

Evaluation of the Project will be conducted jointly by the two Governments through JICA and the Zambian authorities concerned, at the middle and during the last six (6) months of the cooperation term in order to examine the level of achievement.

VI. CLAIMS AGAINST JAPANESE EXPERTS

The Government of the Republic of Zambia undertakes to bear claims, if any arises, against the Japanese experts engaged in technical cooperation for the Project resulting from, occurring in the course of, or otherwise connected with the discharge of their official functions in the Republic of Zambia except for those arising from the willful misconduct or gross negligence of the Japanese experts.

VII. MUTUAL CONSULTATION

There will be mutual consultation between the two Governments on any major issues arising from, or in connection with this Attached Document.

VIII. MEASURES TO PROMOTE UNDERSTANDING OF AND SUPPORT FOR THE PROJECT

For the purpose of promoting support for the Project among the people of the Republic of Zambia, the Government of the Republic of Zambia will take appropriate measures to make the Project widely known to the people of the Republic of Zambia.

IX. TERM OF COOPERATION

The duration of the technical cooperation for the Project under this Attached Document will be five (5) years from 15 July, 2002.

ANNEX I MASTER PLAN
ANNEX II LIST OF JAPANESE EXPERTS
ANNEX III LIST OF MACHINERY AND EQUIPMENT
ANNEX IV PRIVILEGES, EXEMPTIONS AND BENEFITS FOR JAPANESE EXPERTS
ANNEX V LIST OF ZAMBIAN COUNTERPART AND ADMINISTRATIVE PERSONNEL
ANNEX VI LIST OF LAND, BUILDINGS AND FACILITIES
ANNEX VII JOINT COORDINATING COMMITTEE

ANNEX I

MASTER PLAN

OVERALL GOAL

Improved health status of under 5 children in Lusaka District.

PROJECT PURPOSE

Improved health status of under 5 children in selected health centre catchments.

OUTPUT OF THE PROJECT

(1) Community-based Child Growth Promotion (CBCGP) is enhanced.
(2) Community-based environmental health services are improved.
(3) Capacity of case identification and community referral for under 5 children is developed.
(4) Capacity of LDHMT to support health centres & community-based organisations (CBOs) is strengthened.

ACTIVITIES OF THE PROJECT

1.1. Develop community based child growth promotion(CBCGP) package at the level of the District
  1.1.a Develop guidelines on and monitoring & evaluation system for community based child growth promotion
  1.1.b Develop and revise training manual for CBCGP
  1.1.c Develop materials for GMP+(training guide, training manual, counseling cards, tarry form, register book and IEC materials)
1.2. Conduct household survey and register under 2 children
1.3. Analyse demand for CHWs & NPs with stakeholders.
1.4. Conduct capacity building
  1.4.a Conduct ToT for DHMT and health centres staff in CHWs/NPs training
  1.4.b Train community members as CHWs and NPs
  1.4.c Orient trained CHWs and NPs to an adopted approach of GMP+
  1.4.d Conduct refresher workshop for CHWs and NPs
  1.4.e Strengthen capacity of NPs in nutrition counseling
1.5. Conduct GMP+ and follow-up activities
1.6. Conduct monitoring and evaluation
  1.6.a Train DHMT and health centre staff in monitoring and evaluation
  1.6.b Conduct monitoring and evaluation following the guidelines
  1.6.c Conduct evaluation meeting at each level of the District, health centre and CBOs

1.7 Develop IEC strategies and promote utilization of IEC activities

1.7.a Develop IEC strategies

1.7.b Conduct IEC activities

1.8 Share information and experience on community based child growth promotion activities

1.8.a Hold joint meeting for CHWs and NPs

1.8.b Conduct field tours for CHWs and NPs within and out of Lusaka

1.8.c Initiate coordination meeting with stakeholders and donors

2.1. Strengthen capacity of George Environmental Health Committee to ensure sustainability

2.2. Develop PHAST guidelines and training manual including visual aids

2.3. Conduct capacity building

2.3.a Conduct ToT for DHMT and HC staff on PHAST approach

2.3.b Hold PHAST workshop and identify priority needs on environmental health in line with child health

2.4. Support CBOs to plan and implement their action plans to address priority needs

2.5. Conduct monitoring and evaluation following guidelines

2.6. Develop and carry out IEC activities concerning environmental health and personal hygiene in communities

2.7. Support cholera control and prevention programme in the community.

2.8. Hold annual workshop for water & sanitation with stakeholders.

3.1 Conduct IMCI workshop

3.1.a Train instructor for IMCI at LDHMT

3.1.b Conduct IMCI workshops for LDHMT and health Centre staff

3.1.c Train CHWs and NPs in Community IMCI

3.2 Develop referral system between HCs and community

3.2.a Review and develop "Referral Forms from community to HCs

3.2.b Promote utilization of "Referral Forms"

3.2.c Establish effective feedback system from HCs to CHWs

3.3 Establish community health post for community referral

3.3.a Conduct feasibility study on health facilities run by CBOs to serve as community referral points

3.3.b Implement pilot project of these health facilities

3.3.c Replicate facilities in other areas

4.1 Institutionalize system of support to CBOs

4.2 Assign LDHMT staff to coordination & supervision of community based health activities

4.3 Train LDHMT staff and health centres in coordinating CBOs and hundling community

based activities

4.4. Conduct monitoring for implementation of community activities on Action Plan of District and HCs

4.5. Conduct capacity building for NHC members in leadership and management pf community based activities

4.6. Conduct institutional building for CBOs

4.6.a Conduct capacity building for CBOs to ensure sustainability

4.6.b Strengthen financial capacity for CBOs

Note: In case in which the Master Plan should be changed due to the situation of the Project, both Governments will agree to and confirm the changes by exchanging Minutes of Meetings.

ANNEX II

LIST OF JAPANESE EXPERTS

1. Long-term experts;
   (1) Chief Advisor
   (2) Coordinator
   (3) Experts in the following fields;
      a. Community Health
      b. Health Planning & Management

2. Short-term experts in the following fields;
   (1) Monitoring and Evaluation
   (2) Participatory Methodologies
   (3) IEC
   (4) equipment maintenance
   (5) Other related fields mutually agreed upon as necessary

Note: Field and term of assignment of experts will be decided in consideration of the progress of the Project through mutual agreement.

ANNEX III

LIST OF MACHINERY AND EQUIPMENT

1. Equipment for training and research in the fields of primary health care.

2. Equipment in other related fields mutually agreed upon necessary

ANNEX IV

PRIVILEGES, EXEMPTIONS AND BENEFITS FOR JAPANESE EXPERTS

1. Exemption from income tax and charges of any kind imposed on or in connection with the living allowances remitted from abroad.

2. Exemption from import and export duties and any other charges imposed on personal and household effects, including food, beverages, and vehicles, imported or locally purchased out of bond within six (6) months of arrival which may be brought in from abroad or taken out of the Republic of Zambia.

   Relevant duties will be paid if the vehicles are disposed to persons not privileged to the exemptions.

   The goods and services procured under the Project should be exempted from Value Added Tax.

3. In case of accident or emergency, the Government of the Republic of Zambia will use all its available means to provide the medical and other necessary assistance to the Japanese experts and their families.

ANNEX V

LIST OF ZAMBIAN COUNTERPART AND ADMINISTRATIVE PERSONNEL

1. Project Director:
   Permanent Secretary for the Ministry of Health

2. Project Manager:
   Director of Lusaka District Health Management Team, District Health Board

3. Counterpart Personnel in the following fields:
   (1) Health Planning and Management
   (2) Community Health
   (3) Primary Health Care
   (4) Health Education
   (5) Medical Equipment
   (6) IEC
   (7) Other personnel mutually agreed upon as necessary

4. Administrative personnel
   (1) Clerks
   (2) Secretaries
   (3) Drivers
   (5) Other supporting staff mutually agreed upon as necessary

ANNEX VI

LIST OF LAND, BUILDINGS AND FACILITIES

1. Sufficient space for the implementation of the Project

2. Offices and other necessary facilities for the Japanese experts

3. Facilities and services such as the supply of electricity, gas and water, sewage systems, telephones and furniture necessary for the activities of the Project

4. Other facilities mutually agreed upon as necessary

ANNEX VII

JOINT COORDINATING COMMITTEE

1. Functions

The Joint Coordinating Committee will meet at least twice a year and whenever the necessity arises:

(1) To formulate the annual work plan of the Project in line with the Record of Discussions;

(2) To review the overall progress of the Project as well as the achievements of the above-mentioned annual work plan;

(3) To review and exchange views on major issues arising from or in connection with the Project;

(4) To formulate progress monitoring report every six months by discussing above-mentioned issues; and

(5) To discuss any issues to be mutually agreed upon as necessary concerning the Project.

2. Composition

(1) Chairperson : Project Director

(2) Co-Chairperson: Japanese Chief Advisor

(3) Members

Zambian side:

(a) Project Manager

(b) Representative from Ministry of Health

(c) Representative from Lusaka City Council

(d) Representative from Ministry of Finance and Development Planning

(e) Representative from Central Board of Health

(f) Representative from Lusaka District Health Board

(g) Other personnel nominated, if necessary

Japanese side:

(a) Coordinator

(b) Experts

(c) Resident Representative of JICA Zambia Office

(d) Other personnel to be dispatched by JICA

Note: 1.Representative(s) of the Embassy of Japan in the Republic of Zambia may attend the

Joint Coordinating Committee meetings as observer(s).

2.Personnel designated by the Chairman of the Joint Coordinating Committee may attend the meeting as observer(s).

MINUTES OF MEETINGS BETWEEN THE JAPANESE IMPLEMENTATION STUDY TEAM AND THE AUTHORITIES CONCERNED OF THE GOVERNMENT OF THE REPUBLIC OF ZAMBIA ON JAPANESE TECHNICAL COOPERATION FOR THE LUSAKA DISTRICT PRIMARY HEALTHCARE PROJECT PHASE I I

The Japanese Implementation Study Team (hereinafter referred to as "the Team"), organized by the Japan International Cooperation Agency and headed by Prof. Takusei Umenai, visited the Republic of Zambia from 24 June, 2002 to 29 June, 2002 for the purpose of working out the details of the technical cooperation program concerning the Lusaka district primary healthcare project phase II (hereinafter referred to as "the Project").

During its stay in the Republic of Zambia, the Team exchanged views and had a series of discussions with the Zambian authorities concerned about activities and implementation of the Project.

As a result of the discussions, the Team and the Ministry of Health of the Republic of Zambia agreed upon the matters referred to in the document attached hereto.

Lusaka , Zambia, 28 June, 2002

Prof. Takusei Umenai
Leader,
Japanese Implementation Study Team,
Japan International Cooperation Agency,
Japan

Dr. Simon K. Miti
Permanent Secretary,
Ministry of Health,
The Republic of Zambia

Asst. Prof. Moses Sinkala
District Director of Health,
Lusaka District Health Management Team
The Republic of Zambia

ATTACHED DOCUMENT

1. PROJECT DESIGN MATRIX

The Project Design Matrix (hereinafter referred to as "the PDM") is commonly used in Japanese technical cooperation in order to manage and implement projects clearly, efficiently and effectively. It is also used as a reference for monitoring and evaluating projects.

The PDM of the Project, initially prepared by the PCM Workshop in March 2002 and elaborated subsequently in Japan, has been reviewed and revised by mutual agreement, and both sides agreed to apply the PDM as shown in ANNEX I with the following understandings;

1) The PDM is a logically designed matrix which defines the initial understanding of the framework for the Project and indicates the logical steps towards the achievement of the Project purpose.
2) The PDM is to be flexibly developed according to the progress and achievement of the Project, upon agreement between Zambian and Japanese sides.

2. PLAN OF OPERATION

The Plan of Operation (hereinafter referred to as "the PO") has been formulated according to the Record of Discussions, on condition that the necessary budget will be allocated for the implementation of the Project by both sides and that the schedule is subject to change within the scope of the Record of Discussions when necessity arises in the course of implementation of the Project.

The PO is shown in Annex II.

3. PROJECT DOCUMENT

Both sides jointly have prepared the Project Document for rationalization of the plan and justification of the project implementation. The content of the Project Document is agreed by both sides and attached in Annex III.

4. REVIEW OF THE PROJECT DESIGN MATRIX AND THE PLAN OF OPERATION

The PDM and the PO will be reviewed by Zambian and Japanese sides in the first six(6) months and, if necessary, can be revised upon the mutual agreement.

ANNEX I	PROJECT DESIGN MATRIX (as of 28 June, 2002)
ANNEX II	PLAN OF OPERATION (as of 28 June, 2002)
ANNEX III	PROJECT DOCUMENT

Project Design Matrix (PDM)

Name of the Project: Lusaka District Primary Health Care Project II | Duration: 5 years (July 2002~July 2007) | Ver No.1

Target Area: Lusaka District* | Target Group: <5 children in selected Health Centre catchments | Date: June 28, 2002

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Super Goal: Reduction in morbidity and mortality among children in Lusaka District	Indicators will be designed after the completion of baseline survey		
Overall Goal: Improved health status of under 5 children in Lusaka District	Indicators will be designed after the completion of baseline survey		• Political and social stability should be maintained
Project Purpose: Improved health status of under 5 children in selected Health Centre catchments	Indicators will be designed after the completion of baseline survey		• Environmental health/housing conditions in the compounds in Lusaka District are not worsened • Donors funding should be maintained at an acceptable level
Outputs: 1. Community-based child growth promotion (CBCGP) is enhanced 2. Community-based environmental health services are improved 3. Capacity of case identification and community referral for under 5 children is developed 4. Capacity of LDHMT to support Health Centres & Community-Based Organisations (CBOs) is strengthened	Indicators will be designed after the completion of baseline survey		• Purchasing power of household income does not decrease significantly
Activities: 1.1 Develop community based child growth promotion (CBCGP) package at the level of the District 1.1.a Develop guidelines on and monitoring & evaluation system for community based child growth promotion 1.1.b Develop and revise training manual for CBCGP 1.1.c Develop materials for GMP+ (training guide, training manual, counselling cards, tarry form, register book and IEC materials) 1.2 Conduct household survey and register under 2 children 1.3 Analyse demand for CHWs & NPs with stakeholders 1.4 Conduct capacity building 1.4.a Conduct ToT for DHMT and Health Centres staff in CHWs/NPs training	Inputs:		• Assurance of steady supply of essential drugs, equipment, consumables vaccines and micronutrients from EDMSS • Adequate number of staff at DHMT and Health Centre levels is secured • CBoH disburses CHIF fund in timely manner

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
1.4.b Train community members as CHWs and NPs 1.4.c Orient trained CHWs and NPs to an adopted approach of GMP+ 1.4.d Conduct refresher workshop for CHWs and NPs 1.4.e Strengthen capacity of NPs in nutrition counselling 1.5 Conduct GMP+ and follow-up activities 1.6 Conduct monitoring and evaluation 1.6.a Train DHMT and health centre staff in monitoring and evaluation 1.6.b Conduct monitoring and evaluation following the guidelines 1.6.c Conduct evaluation meeting at each level of the District, Health Centre and CBOs 1.7 Develop IEC strategies and promote utilization of IEC activities 1.7.a Develop IEC strategies 1.7.b Conduct IEC activities 1.8 Share information and experience on community based child growth promotion activities 1.8.a Hold joint meeting for CHWs and NPs 1.8.b Conduct field trips for CHWs and NPs within and out of Lusaka 1.8.c Initiate coordination meeting with stakeholders & donors			
2.1 Strengthen capacity of George Environmental Health Committee to ensure sustainability 2.2 Develop PHAST guidelines and training manual including visual aids 2.3 Conduct capacity building 2.3.a Conduct TOT for DHMT and HC staff on PHAST approach 2.3.b Hold PHAST workshop and identify priority needs on environmental health 2.4 Support CBOs to plan and implement their action plans to address priority needs in line with child health 2.5 Conduct monitoring and evaluation following the guidelines 2.6 Develop and carry out IEC activities concerning environmental health and personal hygiene in communities 2.7 Support cholera control and prevention programme in the community 2.8 Hold annual workshop for water & sanitation with stakeholders			

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
3.1 Conduct IMCI workshop 3.1.a Train instructor for IMCI at LDHMT 3.1.b Conduct IMCI workshops for LDHMT and Health Canter staff 3.1.c Train CHWs and NPs in community IMCI 3.2 Develop referral system between HCs and community 3.2.a Review and develop "Referral Forms" from community to HCs 3.2.b Promote utilisation of "Referral Forms" 3.2.c Establish effective feedback system from HCs to CHWs 3.3 Establish community health post for community referral 3.3.a Conduct feasibility study on health facilities run by CBOs to serve as community referral points 3.3.b Implement Pilot project of these health facilities 3.3.c Replicate facilities in other areas			
4.1. Institutionalise system of support to CBOs 4.2. Assign LDHMT staff to coordination & supervision of community based health activities 4.3. Train LDHMT staff and Health Centres in coordinating CBOs and handling community based activities 4.4. Conduct monitoring for implementation of community activities on Action Plans of District and HCs 4.5. Conduct capacity building for NHC members in leadership and management of community based activities 4.6 Conduct institutional building for CBOs 4.6.a Conduct capacity building for CBOs to ensure sustainability 4.6.b Strengthen financial capacity for CBOs			

Note *: The Project will focus, as initial target sites, six Health Centre catchments including Chipata, Chawama, George, Kanyama, Mtendere, and Ng'ombe. However, this selection can be reviewed and revised as need arises, and in reference to the following criteria:

- Where Public Health Problems such as cholera, dysentery and other child diarrhoeal diseases are prevalent;
- Where burden of disease is relatively heavier, and/or poverty is prevalent;
- Where there are observed problematic patters of health-seeking behaviour;

- Where institutional capacity building was done by Phase I of the Project;
- Where other donors' projects/activities are still weak in the similar area of interventions;
- Where there is a need/opportunities for enhancing community participation; and/or,
- Other criterion/criteria as agreed upon in the Project's Steering Committee.

OUTPUT 1: Community-based Child Growth Promotion (CBCGP) is enhanced

Activities	Expected Results	Schedule	Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
		2002: 3Q 4Q; 2003: 1Q 2Q 3Q 4Q; 2004: 1Q 2Q 3Q 4Q; 2005: 1Q 2Q 3Q 4Q; 2006: 1Q 2Q 3Q 4Q; 2007: 1Q 2Q					
1.1. Develop CBCGP package at the level of the District	CBCGP package at the level of the District is developed and standardized						
1.1.a Develop guidelines on and monitoring and evaluation system for CBCGP	Guidelines on and monitoring and evaluation system for CBCGP is developed	◄——►	MPD	CBCGP Task Force	Stationery	Workshop cost	Coordination with stakeholders
1.1.b Develop and review materials for CBCGP	Training manual for CBCGP is developed	◄——►	MPD	CBCGP Task Force	Stationery	Printing cost	Coordination with stakeholders
1.1.c Develop materials for GMP+ (training guide, training manual, counselling card, tarry form, register book, IEC materials)	Materials for GMP+ is developed	◄——►	MPD	CBCGP Task Force	Stationery	Printing cost	Coordination with stakeholders
1.2 Conduct house hold survey for registration of under 2 children	Household survey conducted at pilot sites is utilized for registration	◄——►	MCH in Charge / Nutritionist	Community health coordinators and CHWs/NPs	Stationary Register book	Printing Survey cost	
1.3 Analyse demand for CHWs & NPs with stakeholders	The number of CHWs and NPs required is identified	◄►	MCH in Charge / Nutritionist	Community health coordinators and CHWs/NPs	Stationary Register book	Printing Survey cost	Coordination with stakeholders
1.4 Conduct capacity building	Capacity of Trainers and CHWs and NPs are upgraded based on the guidelines						

Activities	Expected Results	Schedule																				Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
		2002		2003				2004				2005				2006				2007						
		3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q					
1.4.a Conduct ToT for DHMT and Health Centres staff in CHWs/NPs training	The required number of Trainers are trained				◆▶							◆▶		◆▶								MCH in Charge / Nutritionist	ToT facilitators	ToT manual	Training cost	
1.4.b Train community members as CHWs & NPs	The required number of CHWs and NPs are trained				◆———						▶											MCH in Charge / Nutritionist	CHWs/NPs trainers	CHW & NPs training manual	Training cost	
1.4.c Orient trained CHWs and NPs to an adopted approach of GMP+	CHWs and NPs are equipped with an adopted approach of GMP+			◆▶																		MCH in Charge / Nutritionist	CHWs/NPs trainers		Training cost	
1.4.d Conduct refresher workshop for CHWs & NPs	Refresher workshop is regularly conducted		◆———								▶	X	X	X	X	X	X	X	X	X	X	MCH in Charge / Nutritionist	CHWs/NPs trainers	Stationary	Workshop cost	
1.4.e Strengthen capacity of NPs in nutrition counselling	Counceling skills of NPs are upgraded		X		X	X	X	X	X	X	X	X	X									Nutritionist	Nps trainors	Manual	Training cost	
1.5 Conduct GMP+ and follow up activities	GMP+ is regularly conducted	◆———																			▶	Community health coordinator	CHWs, NPs, HC staff	GMP+ sets		
1.6 Conduct monitoring and evaluation	Monitoring and evaluation is effectively conducted																									
1.6.a Train DHMT and Health Center staff in monitoring and evaluation	Monitoring and evaluation skills are gained by HC staff				X							X		X								Nutritionist/ MCH in charge	GMP task force	Stationary	Training cost Manual cost	
1.6.b Conduct monitoring & evaluation following the guidelines	Monitoring and evaluation is conducted				X		X		X		X		X		X		X		X			MCH in Charge / Nutritionist	GMP task force	Stationary		

Activities	Expected Results	Schedule																				Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
		2002		2003				2004				2005				2006				2007						
		3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q					
1.7 Develop IEC strategies and promote utilization of IEC activities	IEC is effectively utilized for improvement of child health																									
1.7.a Develop IEC strategies	IEC strategies are developed	◄		———		►																MCH in Charge / Nutritionist	GMP task force		Materials developing cost	
1.7.b Conduct IEC activities	IEC activities are conducted					◄		———													►	MCH in Charge / Nutritionist	Coordinators and CHWs / NPs			
1.8 Share information and experience on community based child growth promotion	Information and experience sharing is promoted																									
1.8.a Hold joint meeting for CHWs and NPs	Joint meeting is regularly held	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MCH in Charge / Nutritionist	Coordinators		Meeting cost	
1.8.b Conduct field trips for CHWs & NPs within and out of Lusaka	Field trip is conducted	X		X		X	X	X		X	X	X		X	X	X		X	X	X		MCH in Charge / Nutritionist	Coordinators and CHWs/NPs		Field trip cost	
1.8.c Initiate coordination meeting with stakeholders & donors	CBCGP activities are coordinated among the District and donors							X				X				X				X		DDH	GMP+ task force		Meeting cost	

OUTPUT 2: Community-based environmental health services are improved

Activities	Expected Results	Schedule: 2002 3Q 4Q	2003 1Q 2Q 3Q 4Q	2004 1Q 2Q 3Q 4Q	2005 1Q 2Q 3Q 4Q	2006 1Q 2Q 3Q 4Q	2007 1Q 2Q	Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
2.1 Strengthen capacity of Gorge Environmental Health Committee to ensure sustainability	Sustainable model of environmental health activities is established	← →						EHT for George	GEHC members	Stationary	Stationary	
2.2 Develop PHAST guidelines and training manual including visual aids	PHAST guidelines and manuals are developed	← →	← →					EHO	EHTs	Stationary	Meeting cost Printing cost	Visual aids suitable for peri-urban setting
2.3 Conduct capacity building	Skills in PHAST approach are upgraded											
2.3.a Conduct ToT for DHMT and HC staff on PHAST approach	15 DHMT and HC staff are trained in PHAST approach		← →	← →	← → ← →	← →		EHO	EHTs	Manual	Training cost	Coordination with GMP+
2.3.b Hold PHAST workshop and identify priority needs on environmental health in line with child health	PHAST workshop is held at each catchments		← →	← →	← →	← →		EHO	Trainers	Manual Visual aids	Workshop cost	
2.4 Support CBOs to plan and implement their action plans to address priority needs	Planed activities are effectively implemented		← →	← →	← →	← →		EHO	EHTs Committee	Stationary	Material cost for pilot project	
2.5 Conduct monitoring and evaluation following guidelines	Monitoring and evaluation is regularly conducted			X	X	X	X	EHO	EHTs	Stationary		
2.6 Develop and carry out IEC activities concerning environmental health and personal hygiene in communities	IEC materials are developed and effectively utilized for IEC activities		← →	← →	← →	← →		EHO	-ditto-		Printing cost	Coordination with LCC

Activities	Expected Results	Schedule																				Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
		2002		2003				2004				2005				2006				2007						
		3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q					
2.7 Support cholera control and prevention programme in the community	Cholera prevention and control activities are conducted					◄	►			◄	►			◄	►			◄	►			MPD EHO	EHTs HCs staff CBOs	Transport IEC material	Sprayers, disinfectants, etc.	
2.8 Hold annual workshop for water & sanitation with stakeholders	Annual meeting is held with stakeholders									◄	►			◄	►			◄	►			DDH	EHTs HCs staff CBOs		Meeting cost	LCC should take initiative

OUTPUT 3: Capacity of case identification and community referral for under 5 children is developed

Activities	Expected Results	Schedule: 2002 3Q 4Q	2003 1Q 2Q 3Q 4Q	2004 1Q 2Q 3Q 4Q	2005 1Q 2Q 3Q 4Q	2006 1Q 2Q 3Q 4Q	2007 1Q 2Q	Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
3.1 Conduct IMCI workshop	IMCI workshop is effectively conducted to improve capacity of case identification											
3.1.a Train instructor for IMCI at LDHMT	DHMT staff are trained as instructor of IMCI		↔					MPD	IMCI coordinator	Training Manual	Training Cost	Collaboration with ZHIP and CARE is required
3.1.b Conduct IMCI workshops for LDHMT and Health Canter staff	DHMT and HC staff are trained in IMCI		↔	↔	↔	↔		MPD HC in charge	IMCI coordinator	Training Manual	Training Cost	v
3.1.c Train CHWs and NPs in community IMCI	CHWs and NPs are trained in community IMCI		↔	↔				MPD HC in charge	Community Coordinator	Training Manual	Training cost	
3.2 Develop referral system between HCs and community	Referral system between HCs and community is effectively established											
3.2.a Review and develop "Referral Forms" from community to HCs	Referral form is adequately designed	↔						MPD	IEC Officer		Printing	
3.2.b Promote utilisation of "Referral Forms"	Referral forms are effectively utilised at all catchments		↔	↔	↔	↔		Med. Sups.	Community Health Coordinators		Workshop cost	
3.2.c Establish effective feedback system from HCs to CHWs	Feedback system is effectively in operation		↔	↔	↔	↔		Med. Sups.	Community Health Coordinators			
3.3 Establish community health post for community referral	Community health posts are constructed as community referral points											

Activities	Expected Results	Schedule																						Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
		2002		2003				2004				2005				2006				2007								
		3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q							
3.3.a Conduct feasibility study on health facilities run by CBOs to serve as community referral points	Feasibility study report is developed				◄	─	►																	DDH	LDHMT (including HC staff)		Consultancy fee	Approval of CBoH required
3.3.b Implement Pilot project of these health facilities	Pilot facility is in operation							◄	─	─	─	►												MPD	LDHMT (including HC staff)		Initial cost	
3.3.c Replicate facilities in other areas	One facility is constructed per selected HC catchments												◄	─	─	─	─	─	─	─	─	►		MPD	LDHMT (including HC staff)		Construction cost	

OUTPUT 4: Capacity of Lusaka District Health Management Team to support Health Centres & Community-based Organisations is strengthened

Activities	Expected Results	Schedule	Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
		2002: 3Q 4Q; 2003: 1Q 2Q 3Q 4Q; 2004: 1Q 2Q 3Q 4Q; 2005: 1Q 2Q 3Q 4Q; 2006: 1Q 2Q 3Q 4Q; 2007: 1Q 2Q					
4.1 Institutionalise system of support to CBOs	Institutionalised system is functioning	◄——— 2003 3Q → 2007 2Q ———►	DDH	LDHMT, HCs, CBOs			CBoH & LDHMB approval needed
4.2 Assign LDHMT staff to coordination & supervision of community based health activities	Community health in charge is in position	◄——— 2003 3Q → 2007 2Q ———►	DDH	MA		allowance	
4.3 Train LDHMT staff and Health Centres in management skills for coordinating CBOs and handling community based activities	45 DHMT and HC staff are trained in management skill	◄—— 2003 3Q → 4Q ——► ◄► 2004 3Q ◄► 2005 3Q ◄► 2006 3Q	MPD	JICA expert LDHMT	IEC IT equipment	Training cost	
4.4 Conduct monitoring for implementation of community activities on Action Plans of District and HCs	Community activities on action plan is properly implemented based on monitoring	◄—— 2003 3Q → 4Q ——► X 2004 3Q X 4Q X 1Q X 2Q X 3Q X 4Q X 1Q X 2Q X 3Q X 4Q X 1Q X 2Q	MPD	Sister in charge		Monitoring cost	
4.5 Conduct capacity building for NHC members in leadership and management of community based activities	Capacity of NHC in managing community activities is strengthened	◄——— 2002 4Q → 2003 4Q ———► ◄► 2004 3Q ◄► 4Q	MPD	Sister in charge		Manual cost Training cost	
4.6 Conduct institutional building for CBOs	Capacity of CBOs in sustainability is strengthen	——— 2003 1Q → 2007 2Q ———					
4.6.a Conduct capacity building to ensure sustainability of CBO's activities	Capacity building training is conducted	◄——— 2002 4Q → 2003 4Q ———► ◄► 2004 3Q ◄► 4Q ◄► 2005 3Q ◄► 4Q	MPD	Community Health Coordinators			

Activities	Expected Results	Schedule																				Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
		2002		2003				2004				2005				2006				2007						
		3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q					
4.6.b Strengthen financial capacity for CBOs	Sustainable mechanism of CBOs is in function									◆	◆	◆	◆		◆	◆						MPD	Community Health Coordinators			

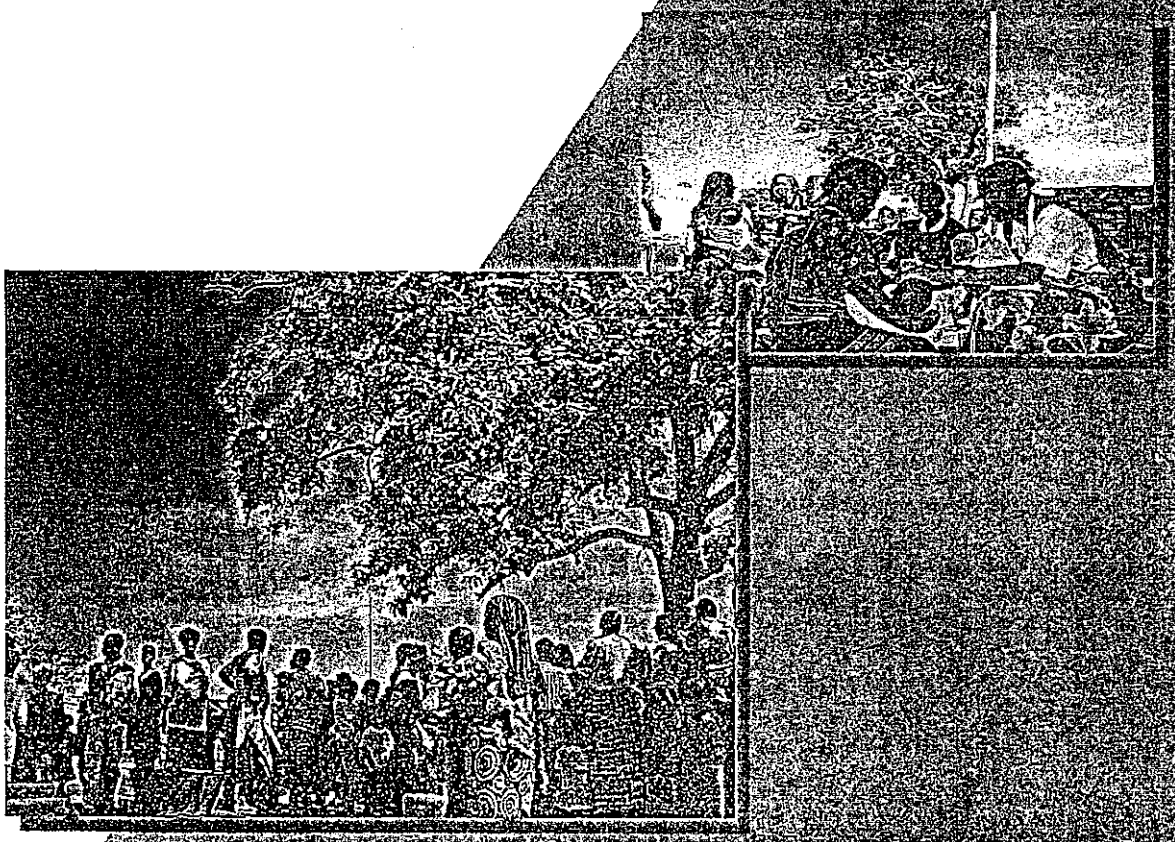
Abbreviations:

Med. Sups.	= Medical Superintendents
MPD	= Manager of Planning Development, Lusaka District Health Office
DDH	= Director of District Health, Lusaka District Health Office
CHW	= Community Health Worker
NP	= Nutrition Promoter
LDHMT	= Lusaka District Health Management Team
HC	= Health Centre
IMCI	= Integrated Management of Childhood Illnesses
CBO	= Community-based Organisation
NHC	= Neighbourhood Health Committee
GEHC	= George Environmental Health Committee
PHAST	= Participatory Hygiene and Sanitation Transformation

LUSAKA DISTRICT PRIMARY HEALTH CARE PROJECT PHASEII (2002~2007)

PROJECT DOCUMENT

June 2002



Lusaka District Health Management Team/JICA

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List of Acronyms

AfDB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infections
BASICS	Basic Support for Institutionalizing Child Survival
BCG	Bacillus Calmette-Guerin
BESSIP	Basic Education Sub-Sector Investment Programme
BoD	Burden of Disease
C3 Fund	City Community Challenge Fund
CBO	Community-Based Organisations
CBoH	Central Board of Health
CFR	Case Fatality Rate
CHP	Child Health Promoter
CHW	Community Health Worker
CHIF	Community Health Innovation Fund
CSO	Central Statistical Office
Danida	Danish International Development Assistance
DDCC	District Development Coordinating Committee
DDH	Director of District Health
DHB	District Health Management Board
DHS	Demographic and Health Survey
DHMT	District Health Management Team
DfID	Directorate for International Development
DOTS	Direct Observed Treatment – Short Course
DPT3	Diphtheria, Whooping Cough, Tetanus (3-in-1 Vaccine)
EDMSS	Essential Drugs and Medical Supply Store
EHT	Environmental Health Technician
EIRR	Economic Internal Rate of Return
ENT	Ear Nose Throat
EPI	Expanded Programme on Immunisation
FAMS	Financial and Administrative Management System
FIRR	Financial Internal Rate of Return
FP	Family Planning
FRESH	Focusing Resource on Effective School Health
GCEP	George Community Empowerment Project
GDP	Gross Domestic Product
GEHC	George Environmental Health Committee
GMP	Growth Monitoring Promotion
GNI	Gross National Income
GRZ	Government of the Republic of Zambia
HC	Health Centre
HCC	Health Centre Committee
HIPC	Heavily Indebted Poor Countries
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IACC - CH	Inter-Agency Coordination Committee on Child Health
ICMR	Infant and Child Mortality Reduction
	Moyo wa Bana

ICU	Intensive Care Unit
IDA	International Development Association
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
ITG	Integrated Treatment Guidelines
IUD	Intra-Uterine Devise
JHAM	Joint Health (pre)Appraisal Mission
JICA	Japan International Cooperation Agency
JIFM	Joint Identification and Formulation Mission
LCC	Lusaka City Council
LCMS	Living Conditions Monitoring Surveys
LDHB	Lusaka District Health Board
LDHMT	Lusaka District Health Management Team
LWSC	Lusaka Water and Sewage Company
MCH	Mother and Child Health
Med. Sups.	Medical Superintendents
MFED	Ministry of Finance and Economic Development
M&E	Monitoring and Evaluation
MLGH	Ministry of Local Government and Housing
MMD	Movement for Multiparty Democracy
MMR	Maternal Mortality Rate/ Ratio
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTCT	Mother to Child Transmission
MPD	Manager of Planning Development
NGO	Non-Governmental Organisations
NFNC	National Food and Nutrition Commission
NHC	Neighbourhood Health Committee
NHSP	National Health Strategic Plan
NP	Nutrition Promoter
OPD	Outpatient Department
OPV3	Oral Poliomyelitis Vaccine
PCM	Project Cycle Management
PCU	Programme Coordination Unit
PDM	Project Design Matrix
PEM	Protein Energy Malnutrition
PHC	Primary Health Care
PHAST	Participatory Hygiene and Sanitation Transformation
PHP	Public Health Practitioner
PLA	Participatory Learning and Action
PNC	Postnatal Care
PO	Plan of Operations
PROSPECT	Poverty Elimination and Community Transformation
RDC	Resident Development Committee
RTI	Respiratory Tract Infections
SCOPE OVC	Strengthening Community Partnerships for the Empowerment of Orphans and Vulnerable Children
Sida	Swedish International Development Cooperation Agency
STD/STI	Sexually Transmitted Disease/Infection
SWAp	Sector Wide Approach
TB	Tuberculosis

TBA	Traditional Birth Attendance
TORs	Terms of Reference
ToT	Training of Trainers
U5MR	Under 5 Mortality Rate
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNIP	United National Independent Party
USAID	United States Agency for International Development
UTH	University Teaching Hospital
UUS	Unplanned Urban Settlements
VIP	Ventilated Improved Pit
VTC	Voluntary Testing and Counselling
WASHE	Water, Sanitation and Hygiene Education
WB	World Bank
WHO	World Health Organisation
ZIHP	Zambia Integrated Health Project
ZIHP COMM	ZIHP Communications and Community Partnership
ZIHPSERVE	ZIHP Service Delivery and NGO Strengthening
ZK	Zambian Kwacha

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Preface

The Japanese Project Preparatory Study Team organised by the Japan International Cooperation Agency (JICA) visited the Republic of Zambia from 24th January, 2002 to 6th February, 2002, for the purpose of the study regarding the Zambian government's request for the Japanese technical cooperation concerning Lusaka District Primary Health Care Project Phase II. During the study by the Team in the Republic of Zambia, the Team exchanged views with the related parties and also organised a series of Project Cycle Management Workshops for planning the Project with participation of Lusaka District Health Management Team, health centre staff, community based organisations, Japanese experts, JICA Zambia Office and other related parties. Two consultants of the Team continued to study and produced the Project Document based on the findings from interviews and surveys with a close consultation with a range of stakeholders until March 2, 2002.

Executive Summary

Despite various efforts made by the Government of the Republic of Zambia (GRZ) and Cooperating Partners under almost a decade-long Health Sector Reform, diseases among children under 5 years of the age, which could be prevented through vaccine and other preventative/promotional measures, still dominate as major factors affecting morbidity and mortality. The situation is exacerbated by the increasing HIV seroprevalence among children.

Concurrently, continuing influx of migrants to urban areas is resulted in formation of vast unplanned settlements in the vicinity of Lusaka, creating poverty pockets with enormous challenges in environmental and public health. Lusaka District Primary Health Care Project (Phase II) will be implemented in order to address these issues.

"***High morbidity and mortality of children***" was identified as the core problem to be tackled by the Project. Morbidity and mortality in Lusaka District owes largely to high prevalence of ***measles***, ***diarrhoea***, ***malaria***, and ***ARI cases***. Factors that negatively influence child health were analysed in different levels. At *family/community level*, ***malnutrition***, ***late case recognition***, ***poor environmental health***, ***poor child care***, and ***HIV/AIDS*** were raised. At *the Health Centre* level, the weakness was pointed out to be ***the lack of capacity to manage the cases appropriately***. Furthermore, the fact that the *Lusaka District Health Management Team (LDHMT)* has ***difficulty in supporting community based health activities***, was also identified as one of the contributing factors.

In redressing the above identified problems, the Project will try to establish a sustainable community-based structure for community cadres to provide essential health services. ***Sustainability measures*** are the central concern of the Project Strategy. Emphasis will be placed on effective use of ***participatory tools and processes triggered thereby***. Another sustainability measure is about ***establishing effective and systematic link*** among policy makers, health management, service providers and service recipients.

The Project is designed with the following components: Overall goal, Project purpose, Outputs, Activities, Inputs, and Important assumptions. In order to realise the Project purpose, "*improved health status of under-5 children in selected health*", four Outputs are selected in the areas of 1) ***capacity building of LDHMT***, 2) ***Community-based child growth promotion*** , 3) ***environmental health***, and 4) ***case identification and community referral***, each of which addresses the causes at different levels, leading to the core problem. After the completion of the Project and with continuous commitment and efforts of LDHMT in cooperation with the concerned parties, the Overall goal is expected to be achieved, which is, "improved health status of under-5 children in Lusaka District".

The Project reflects the priority needs specified through the participatory planning process and health policy documents. The target group is under-5 children ~ the most vulnerable group: numbering approximately 180,000; 20% out of 439,596 people residing in initially selected HC catchments. Positive impacts of the Project are expected to go beyond reduced morbidity and mortality, but to increased productivity and income. Moreover, the Project intends to bring positive influences on national health policies and on institutional mechanism at district level. All of these results are to contribute to increased sustainability in provision of public health services.

Monitoring and evaluation activities are integral parts of the Project activities, and will be utilised to improve the design of the Project. The results are also to be shared with relevant stakeholders.

1. Introduction

1.1. As per request by the Government of the Republic of Zambia (GRZ), the Government of Japan has assisted GRZ with Lusaka District Primary Health Care (PHC) Project (1997~2002) with a cooperation period of 5 years. The George compound was selected as a pilot site for the community-based PHC programmes focusing on prevention of malnutrition and infectious diseases among children. Support to enhance referral system, school education and water and sanitation were also incorporated to enhance overall performance of the Project.

1.2. The Evaluation of the Project was carried out in October 2001, where the community-based interventions under the Project were well recognized to be applied in the future for other PHC projects in urban settings. Recommendation was made that the experiences be replicated in other compounds of Lusaka. As per the recommendation, and as per a request from the GRZ, the Japan International Cooperation Agency (JICA) provided Project Preparatory Study Mission in January ~ March 2002 to help prepare a successor project (***Lusaka District PHC Project Phase II: 2002-2007***), with a view to ***expand the coverage*** to other unplanned settlements.

1.3. This Project Document was developed with the close participation of and consultation with a range of stakeholders including Ministry of Health (MoH), Central Bureau of Health (CBoH), National Food and Nutrition Commission (NFNC), Ministry of Education (MoE), UNICEF, Lusaka City Council (LCC), various health cadres under Lusaka District Health Management Team (LDHMT), community-based organisations (CBOs), and concerned Non-Governmental Organisations (NGOs). Development of the project design owes largely to the Project Cycle Management (PCM) Workshops held in January and February 2002. Based on the draft Project Design Matrix (PDM), the Project Document were further elaborated by the Project Preparatory Study Team, with results from individual and group interviews, rapid site surveys, and Institutional Development and Organisational Strengthening (ID/OS) workshop.

1.4. The Project Document is mainly composed of seven parts. Following the ***Introduction*** (Chapter One), ***Chapter Two*** tries to identify current situation and issues to be addressed by this Project, as well as to give a general picture of existing government strategies, plans and efforts to address such issues. ***Chapter Three*** provides more in-depth picture of the current institutional framework to address these issues, as well as the analyses to identify factors that affect these problems. Based on discussions in the previous chapters, ***Chapter Four*** describes the Project Strategy, in other words, how this Project tries to solve the problems concerned. This is followed by a description of the Project content in ***Chapter Five***, explained in terms of Overall goal Project purpose, Outputs and Activities, with reference to the risk factors. Relevance, feasibility and expected results of the Project are discussed in ***Chapter Six***. Finally but not the least, ***Chapter Seven*** refers to the Monitoring and Evaluation arrangements. For easier reference, summary of the Project can be found in the form of ***PDM*** and ***Plan of Operations*** (PO), which are attached as Annexes.

2. Background

Despite various efforts made by the Government of the GRZ and Cooperating Partners under almost a decade-long Health Sector Reform, the achievements are yet to be reflected to life expectancy or burden of disease (BoD) indicators. Among children under 5 years of the age, diseases that could be prevented through vaccine and other preventative/promotional measures still dominate as major factors affecting morbidity and mortality. The situation is exacerbated by the increasing HIV seroprevalence among children.

Concurrently, continuing influx of migrants to urban areas is resulted in formation of vast unplanned settlements in the vicinity of Lusaka, creating poverty pockets with enormous challenges in environmental and public health.

2.1 Macro-economic context

2.1. In 1992, the former President, Dr. F. J. T. Chiluba introduced a series of ambitious market-oriented reforms, which included trade and exchange rate liberalization, parastatal reform and privatisation, and removal of state subsidies. In the 1990s, declined price of international copper markets, drought and aid stagnation due to governance concerns all prevented sustained economic growth. However, the economy has begun to show some signs of recovery in the beginning of 2000, and it grew 3.5 percent in 2000, with its non-mining share also increased by 4.1 percent. GDP is expected to grow 5 percent in 2001 (World Bank, 2001).

2.2. In December 2000, provision of the debt relief granted to Zambia under the HIPC Initiative, is also expected to have positive effects on its economy[1]. The impact of this relief on the 2002 budget of the Health Sector, whether national or district level, are yet to be seen.

2.2 Socio-economic context

2.3. Despite the gradual recovery of economic status, per capita GNP is on decline, from US$350 in 1995, US$320 in 1999, to US$300 in 2000[2]. Low income status is exacerbated by its highly skewed distribution with the Gini-coefficient being 0.51. According to the 1996 Living Conditions Monitoring Survey, 78% of the population were estimated to be either moderately or extremely poor, with figures reaching 85% and over in some districts (World Bank, 2001).

2.4. It should also be noted that whilst marginal decreases in the incidence of poverty were observed in rural provinces, national counts rose from 69% to 73% between 1996 and 1998 (CSO, 1998), indicating high rise in poverty occurrence in urban areas. In urban areas, causes of poverty are explained in terms of the lack of gainful employment opportunities, poor and expensive health and education facilities notwithstanding the proximity of service facilities, heavy disease burden and late payments of retirement benefits (MFED, 2001).

2.5. Deficiencies in water supply and sanitation are seen to be significant and growing

1 HIPCS fund available for the fiscal year 2002 is K57 billion for the health sector, 15.4% out of K371 billion for the whole sector nation-wide.
2 This is also substantially lower than the average for sub-Saharan Africa, which is US$480 in 2000 (World Bank, 2001).

problems that dispose the population to dangerous health hazards such as diarrhoeal diseases and parasitic infections, especially in unplanned compounds of the country. Less than half of the population (43%) is said to have an access to safe water. Primary school enrolment rate is 89%, better than the average of Sub-Saharan Africa. Female school enrolment, though, recorded 86% to that of male counterparts.

Table 2.1 Basic Socio-economic Indicators: Zambia and Sub-Saharan Africa

	Indicators		Year	Source
	Zambia	S.S.A.		
Surface Area (km^2)	752.6	...	1999	WB
Total Population (in million)	10,1	659.0	2000	WB
Urban Population (%)	44.0	34.0	2000	WB
Population Increase (%)	2.2	...	1999	WB
Life Expectancy at Birth (years of age)	45.0	47.0	2000	WB
GNP per capita (US$)	320.0	...	2000	UNICEF
GDP Growth Rate (%)	3.5	...	2000	WB
Population below Poverty Line (%)	73.0	...	2000	WB
Illiteracy Rate (%)	22.0	38.0	2000	WB
Primary School Enrolment Rate (%)	89.0	78.0	2000	WB
Female School Enrolment (%)	86.0	71.0	2000	WB
Infant Mortality Rate (in 1,000 live births)	114.0	92.0	2000	WB
Under 5 Mortality Rate (in 1,000 live births)	202.0	169.0	2000/98	UNICEF
Malnutrition Prevalence	27.0	30.0	2000	WB/UN
Maternal Mortality Rate (in 100,000 live births)	650.0	975.0	2000/98	UN
Contraceptive Prevalence Rate(%)	26.0	...	2000	UNICEF
HIV Infection Rate (%)	19.7	...	1998	UNDP
Number of AIDS cases (per 100,000)	46.9	11.2	1996/98	DHS/UN
Population with Access to Safe Water (%)	43.0	55.0	2000	WB

Source: WB (2000), UNICEF (1998/2000), UN (1998/2000), UNDP (1998), DHS (1996)

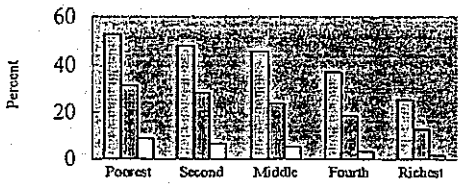
2.3 Health status

2.6. Life expectancy has declined significantly to the estimated 37.0 years in 2000, as compared to 54 years at the end of the 1980s. Malaria, malnutrition and AIDS are major factors affecting morbidity and mortality, added by overwhelming increase in tuberculosis incidence rate from 1 per 1,000 to 5 per 1,000. Over 20% of the adult population is said to be HIV-infected, urban areas more severely affected (29%) than rural areas(14%) (MoH/UTH/JICA, 2002) . Maternal mortality rate is quite high at 649 per 100,000 live births, and is one of the worst in Africa (USAID, 2001).

2.7. Infant and Under-5 mortality rates are 114 and 202, respectively, out of 1,000 live births, which are higher than the average (92, 169) of sub-Saharan Africa. Over 600,000 children are orphans; this is projected to rise to 1.6 million in the next few years. Factors like

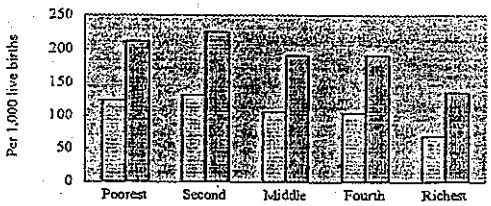
increasing poverty, increasing incidence of AIDS and parasite resistance against chloroquine, contribute largely to deterioration in the health status of children (JIFM, 2000). Malaria, acute respiratory tract infections, diarrhoea disease, and vaccine-preventable diseases continue to dominate child morbidity and mortality (HMIS, 1999). Malnutrition and underweight among children under 5 years of the age remain high. Percent of stunted children was at high rate of 53%, which is worsened from the status (46%) of 1996 (MFED, 2001). Perhaps quite predictably, these health indicators show differentiation in terms of income quintiles, as shown in Figure 2.1 and 2.2.

Figure 2.1 Nutrition Status of Children per income quantile (1998)



	Poorest	Second	Middle	Fourth	Richest
Stunted (%)	52.8	48	45.6	37.1	25.4
Underweight (% moderate)	31.6	28.3	23.8	18.4	12.9
Underweight (% severe)	8.7	6.6	5.2	3.3	1.8

Figure 2.2 IMR and U5MR Per Income Quantile (1998)



	Poorest	Second	Middle	Fourth	Richest
IMR	123.6	131.5	105.1	104.1	69.8
U5MR	212.3	225.9	191.1	191.1	135.6

2.4 Demographic context

2.8. The 2000 Census estimated that the total population of Zambia was 10.5-11.1 million, with an average annual growth rate of 2.5%. Zambia holds approximately 44% of its population in urban areas, being one of the most urbanised in sub-Saharan Africa (World Bank, 2000). Migratory trend into vicinity of the capital, especially to the Unplanned Urban Settlements (UUS) was accelerated due to the retrenchment of employees as privatisation and reform of the parastatal firms continued.

2.9. Influx of urban migration posed the local authorities great challenge in meeting swelling demands for social services such as provision of potable water, sanitation facilities, health care, education, etc. Although large discrepancies in access to safe water and adequate sanitation between rural and urban areas has been pointed out[3](WHO, 2000), this observation is misleading when considering peri-urban context where access to social services are severely limited.

2.10. Growing population pressure and swelling disease burden in urban poverty-stricken areas render major challenge to Zambian Health sector. Nevertheless, the country relies heavily on external assistance. Over 45% out of ZK209.2 billion (1998 estimated expenditure) was sourced from external aid resources through bilateral contributions, tied, aid, loans, etc (JIFM, 2000). In such a context there seems to be a tendency that routine provision of curative services at health facilities outweighs preventative and promotional services, as well as in-service

[3] Current coverage of water and sanitation is 88% and 99% of the urban population, respectively, whilst only 48% and 64% in rural areas.

training.

2.5 Description of the sector/sub-sector

2.5.1 General profile of Lusaka District

2.11. Lusaka district hosts the capital of the Republic of Zambia, and is located in Lusaka Province in the central part of the country. The climate of Lusaka can be broken down into three distinct seasons: the hot and dry season (August to October); the hot and rainy season (November to April); and, the cold and windy season (May to July). The district has surface area of 360 km^2, and is a home for 1,102,413 people, which is 10.7% of the total population of Zambia (CSO, 2001). That makes exceptionally high population density of 3,065 people per square kilometre, as compared to the national average of 13.7 per sq km. According to a WHO estimate, 19% of population in Lusaka is estimated to live in UUS (WHO, 2000). There are few credible sources existing on migration trend of population settled in Lusaka unplanned areas. Average annual population growth rate for Lusaka District recorded slight increase at 3.8%[4], compared to 3.6% between 1980-1990 (CSO, 2001; JICA, 2001).

2.5.2 Disease pattern in Lusaka District

2.12. The following tables show some data reflective of health status of children under 5 years of the age. Health status of children in Lusaka District is reflective of nation-wide situation. Priority diseases to be addressed are malaria, respiratory tract infections, diarrhoea, pneumonia, intestinal worms, malnutrition and vaccine preventable diseases such as measles. It can be inferred that many of these diseases have to do with poor sanitation and water quality, and that much can be done through promotional and preventative interventions.

Table 2.2 Top 10 Causes of Morbidity (Under-5 Children)

No	1999			2000			2001 June		
	Causes	Cases	Incid	Causes	Cases	Incid	Causes	Cases	Incid
1	Malaria	65,944	218.1	Malaria	80,982	252.0	Malaria	84,318	246.8
2	RTI	66,385	134.7	RTI	52,901	164.6	RTI	51,968	152.1
3	Diarrhoea (non-bloody)	38,849	128.5	Diarrhoea (non-bloody)	50,121	156.0	Diarrhoea (non-bloody)	44,565	130.5
4	Pneumonia	15,528	51.4	Pneumonia	21,963	68.3	Pneumonia	28,216	82.6
5	Skin Infection	10,456	34.6	Intest. Worms	16,170	50.3	SkinInfection	15,268	44.7
6	Intest. Worms	10,206	33.8	Skin Infection	14,790	46.0	Intest. Worms	15,069	44.1
7	Trauma	5,332	17.6	ENT diseases	13,719	42.7	ENT diseases	11,525	33.7
8	Skin Diseases	3,915	13.0	Eye Infections	10,968	34.1	Trauma	6,417	18.8
9	Anaemia	3,770	12.3	Trauma	10,006	31.1	Anaemia	5,861	17.2
10	ENT diseases	2,808		PEM	5,968	18.6	PEM	4,878	14.3

Source: LDHMT data (2001)

[4] The rate showed sex differences: female 4.0% and male 3.6%.

Table 2.3 Top 10 Causes of Mortality (Under-5 Children)

No	1999			2000			2001 June		
	Causes	Death	CFR	Causes	Death	CFR	Causes	Death	CFR
1	Malaria	31	11.1	Pneumonia	23	16.1	Malaria	31	12
2	Pneumonia	30	24.4	Malaria	17	4.7	Pneumonia	24	15.6
3	Diarrhoea (non-bloody)	22	53.3	PEM	9	69.1	Diarrhoea (non-bloody)	15	25.2
4	RTI	15	17.3	Anaemia	8	51.6	PEM	5	57.5
5	PEM	3	29.7	AIDS	8	163.3	Meningitis	3	200.0
6	Measles	3	17.5	Diarrhoea (non-bloody)	7	13.9	Diarrhoea w/ dehydration	2	9.2
7	Diarrhoea w/ dehydration	2	14.4	Diarrhoea w/ dehydration	5	35.5	TB (suspect & confirm)	1	32.3
8	Anaemia	1	8.7	Meningitis	3	125.0	Digestive system (non-infectious)	1	250.0
9	Pulmonary (no-infectious)	1	55.6	Pulmonary (no-infectious)	2	62.5	-	-	
10	Skin infect.	1	142.9	Measles	2	31.3	-	-	

Source: LDHMT data (2001)

Table 2.4 Immunisation/Vitamin A coverage

Antigen	1999		2000		2001 June	
	Target	Coverage	Target	Coverage	Target	Coverage
BCG	65%	45%	65%	76%	80%	67%
OPV3	68%	56%	68%	78%	75%	88%
DPT3	68%	56%	68%	86%	75%	71%
Measles	62%	44%	62%	59%	70%	51%
Fully immunised (0-11 months)	95%	44%	95%	101%	98%	48%
Vitamin A (6mon-6yr)	80%	94%	90%	69%	70%	89%

Source: LDHMT data (2001)

Table 2.5 Nutrition Status of Under-5 Children

Indicator	1999		2000		2001 June	
	No	%	No	%	No	%
Total no of children weighed	400,665	13%	421,884	11%	320,778	12%
No children below lower line	52,756		46,307		38,394	

Source: LDHMT data (2001)

2.13. Child health services provision may require some boost. Although the year 2000 coverage for fully immunised children under 12 months recorded 101%, general coverage is still low. Among the under 5 children who attended growth monitoring programmes, one out of ten were malnourished.

2.14. One should note that most of the data presented above is institution-based, *i.e.* not based on community-based sample surveys. Therefore, these data include only those who seek services at public health centers.

2.5.3 Water supply and sanitation situation of Lusaka District

2.15. The situation analysis preceding to the formulation of the Peri-Urban Water Supply and Sanitation Strategy revealed that water supply and sanitation services in peri-urban areas are

poor, inadequate, unreliable. According to the Lusaka District Health Management Board (LDHMB) Action Plan 2002, sixty percent (60%) of the population in Lusaka District have access to piped water, whilst the other forty percent (40%) of the population in Lusaka uses shallow wells. Use of shallow wells can be typically seen in these expanding unplanned compounds. The capacity of existing water supply system (from 53 boreholes and the Kafue River), provided by the Lusaka Water and Sewage Company (LWSC), has been quite insufficient both in terms of quality and quantity, resulting from contamination due to badly maintained supply and drainage facilities, as well as growing population pressure.

2.16. Only one third of the city enjoys excreta and liquid waste disposal system. Residents in unplanned settlements use pit latrines, often shared by several households. Ventilated Improved Pit (VIP) latrines are also used in the areas, although few in number. Some, if not most, of these conventional pit latrines in unplanned compounds are temporary structure without permanent walls, roofs, or septic tanks. Drainage system is underdeveloped in unplanned areas, and even if it exists, it is frequently the case that it is blocked with garbage or mud piling up over time, due to poor maintenance. In the rainy season, these latrine pits are susceptible of overflowing excreta waste out of pits. This together with blocked or absence of adequate drainage, results in developing stagnant water on the streets, offering breeding ground for vector such as flies and mosquitoes.

2.17. Solid waste management service covers only a segment of the District/City, such as central business district, government and commercial institutions. Heaps of garbage along the roads, markets, and open spaces are ubiquitous, and intensified in unplanned settlements where population concentration is high. Prevalence of vermin predisposes the residents to outbreaks of infectious diseases such as cholera and plague.

2.5.4 Socio-economic situation in Lusaka unplanned settlements

2.18. There are limited amount of data available on socio-economic situation in urban unplanned settlements.

2.19. According to the baseline survey conducted in George, Chawama and Chaisa during Phase I of the Lusaka District Primary Health Care Project (hereafter referred to as "Phase I of the Project")in 1998, about three quarters of the population (77.2%) is literate. Among the above 6 years population, 17.4% have no education and 56.5% complete primary education. In another JICA study done in Ng'ombe compound, reasons for school drop out are dominated by economic factors (77%), some combined with demanding domestic workloads (9%). With regard to occupation, 37.9% of people above 7 years old were working for income or had a job, one month before the survey. Most common occupations are in service sector (47.2%), bricklaying (19.0%) and agriculture (9.0%). More than half of the population in the three compounds earned less than ZK100,000 in the month prior to the survey. In other compounds, 44% earned ZK50,000 – 100,000, 37% less than ZK50,000, whilst 14% earned ZK100,000-150,000 as an average monthly household income.

2.20. There are differences in access to tap water in unplanned areas. In Bauleni and Chibolya compounds, 95% and 31.2% use public taps, respectively, compared to 4% and 57% using private taps. In areas serviced by tap water, the biggest challenges are more on maintenance of water places, ensuring good quality and quantity of water, and adequate

collection of monthly fees. Physical access to the water places is not much of a problem. In some areas, and for some poor households, shallow wells, often contaminated, serve for their needs as a source of free water. Even a water tap allocated per plot can function as a public tap, which sometimes causes inadequate maintenance of a water place. Most common ways of garbage disposal in "compound" are dumping at collection site, and burying in a pit. Whilst majority uses conventional pit latrines for their excreta disposal, the structure is usually either temporary and/or without a roof, often stolen or vandalised.

2.21. In the three survey areas, 37.2% of people live in their own houses, whilst others resort to renting. In another JICA-funded survey in Ng'ombe and Chibolya, more than half had either land occupancy certificate or title deed, whilst 30.3% were renting land/housing units. One can observe that there are quite a few number of households in these compounds with proper ventilation. There is a general tendency to keep windows very small and few for security reasons. In the survey, 78.4% of the household used charcoals as main source of energy.

2.6 Host country strategy

2.6.1 National development plan and health sector strategy

2.22. Zambia does not produce 5-year national development plans anymore, ever since political power shifted from UNIP to MMD regime in 1991. Equivalent to a national development plan are independent sectoral strategies formulated and implemented by line ministries. Nevertheless, with technical and financial assistance from the World Bank and UNDP, the country is preparing a long-term development plan called "Zambia Long-Term Development Vision 2025," under which a multi-sectoral 5-year plan will be attached.

2.23. In addition to the above undertakings, Zambia drafted the Poverty Reduction Strategy Paper (PRSP) on September 2001, which include chapters on Water, Health and HIV/AIDS. Contents and priority areas in the Health Chapter do not have much difference from those of on-going Health Sector Reform and of Sector Wide Approach (SWAps), except that the Paper stresses more on cost-sharing and user fee component, as well as resource allocation with consideration to issues of poverty.

2.6.2 Health Sector Reform and the National Health Strategic Plan (2001 – 2005)

2.24. Since 1992, Zambia has been implementing series of health sector reform measures, including SWAps, in line with a policy document, National Health Policies and Strategies[5]. MoH together with CBoH are implementing agencies of SWAps at national level, whilst District Health Management Team is responsible for management and implementation of programmes relating to services provision[6].

2.25. Two sets of "paradigm shift" characterises the Health Sector Reform. One is project and programmatic funding to that of the SWAps. The other is to weigh more on "service

[5] The Strategy was approved by the Cabinet in 1992.
[6] For more information on Health Sector Reform and SWAps, please refer to the Report by Ms. N. Toyoshi, December 2001.

delivery" than "capacity development" when strategising the reform interventions. Indeed, Zambia is one of the pioneers of the concept of the "package" of basic services, and of the "basket" approach[7] for international donor support.

2.26. The vision of the Zambian health reform, which is also stipulated in the National Health Strategic Plan (NHSP), is *"to provide Zambians with equity of access to cost effective, quality health care as close to the family as possible."* The primary strategy for achieving this vision is through decentralization of resources and responsibilities to the district level and below. There are four principles to guide the reform process, as shown in the Box 2.1.

2.27. In line with the said Policies and Strategies, a National Health Strategic plan is periodically revised to articulate present needs which require focus. The Strategy has five objectives, which are:

1. Equal access to health services;
2. Improvement of life expectancy;
3. Improvement of environmental health;
4. Promotion of healthy lifestyles; and,
5. Provision of quality medical services.

Box 2.1: Four principles underpinning the Zambian Health Sector Reform

1) *Leadership*–building the capacities of the health providers at the various levels of operation
2) *Accountability*–for the quality of the services they provide, and in terms of their responsiveness to the communities they serve
3) *Partnership*–bringing together a positive relationship between and among, all elements who interface in health service
4) *Affordability*–which embraces the twin objectives of a more efficient utilisation of available resources and the mobilisation of additional resources in support of the health sector.

2.28. Public health priority areas for the NHSP (2001 – 2004) were identified as below by the Health (Pre)Appraisal Mission (JHAM, 2001):

1. Malaria;
2. HIV/AIDS/STI;
3. Integrated reproductive health;
4. Child health;
5. Mental and oral health;
6. Improved public health surveillance and epidemics control; and,
7. Promotion of safe water, hygiene and sanitation.

2.29. In order to address the above priority areas, main challenges include:

- ✓ Redressing unsatisfactory quality of services;
- ✓ Delivering within limited local financial resources;
- ✓ Meeting increasing demands due to changing demographic and disease patterns; and,
- ✓ Redressing differential access to and utilisation of health services.

[7] Currently, basket funding approach is not in place at the national level, but only at the district level. District Basket resources are monitored by the Health Sector Committee, consisting of CBoH, MoH, NGOs, and Donor Agencies.

2.6.3 National strategy for water and sanitation sector

2.30. Government of Zambia launched the water sector reform in March 1993, with the growing recognition that the sector has been failing to deliver an acceptable level of service to the urban, peri-urban, and rural communities and that the failure was more due to institutional, legislative, and organisational weaknesses. This reform process is coordinated through the Programme Coordination Unit (PCU), which is an inter-ministerial committee meeting chaired by the permanent secretary of Ministry of Energy and Water Development. The PCU meets every quarter discussing all issues of water supply and sanitation.

2.31. The National Water Policy, which was adopted by the Government in 1993, outlines the seven principles (Please refer to Box 2.2) for the reform process to follow. There is also the National Water Supply and Sanitation Strategy for Rural and Peri-urban Areas in Zambia, which was launched in 1998. The Strategy outlines institutional arrangements for water and sanitation provision in the rural and peri-urban areas, financing arrangements and advocacy issues. District Councils, under the Ministry of Local Government and Housing (MLGH), owe decentralised government responsibility for provision of water supply and sanitation services.

Box 2.2: Seven principles underpinning the National Water Policy (1993)

1. Separation of water resource management from water supply and sanitation
2. Separation of regulatory and executive functions
3. Devolution of authority to local authorities and private enterprises
4. Full cost recovery in the long run
5. Human Resource Development leading to more effective institutions
6. Technology appropriate to more effective institutions
7. Increased GRZ priority and budget spending to the sector

2.32. The Strategy stresses promotion of an integrated partnership among sanitation, health and water supply sectors, of demand-responsive and community-based approaches, as well as greater prominence over behavioural change than provision of facilities. In rural settings the government has adopted Water, Sanitation and Health Education (WASHE) concept[8] as the basis for its intervention strategy, and implemented in 65 out of 72 districts of Zambia.

2.6.4 National strategy for school health and nutrition

2.33. Ministry of Education (MoE), under the Basic Education Sub-Sector Investment Programme (BESSIP), has recently embarked on the comprehensive program on school health and nutrition called "Focusing Resource on Effective School Health (FRESH)."

2.34. The FRESH has four priority intervention areas:

1 Improvement of water, sanitation, and hygiene practices;

2 Provision of health and nutrition education within Life Skills;

[8] WASHE is a community-focused framework in providing water and sanitation services. Service delivery function of water and sanitation is handed to community-based organisations such as D-WASHE committee by whom planning, implementing, managing and monitoring of water and sanitation will be carried out.

3 Draft guideline of health and nutrition for teachers and children was already developed. Information is to be disseminated regarding nutrition, hygiene, HIV/AIDS and other key issues ; and,

4 Formulation of school health related policy.

2.35. Piloting of the FRESH approach has been completed in two districts of Eastern Province, and the approach is ready for replication to other districts, but not including Lusaka. The draft National School Health and Nutrition Policy has been completed and will be in circulation for comments. In addition, a guideline on how to incorporate health and nutrition in school curriculum is to be printed soon. MoH and MoE have collaborative relationship through MoU, (e.g. MoH cadres training MoE teachers on health and nutrition issues), whereby the MoH provides technical expertise that the MoE requires to implement health-related interventions.

2.7 Prior and ongoing assistance

2.7.1 Community-based health/sanitation programmes

2.36. Under the ***Health Sector Reform***, a large number of programs/projects have been implemented for a long period in Zambia to promote community-based health and sanitation activities. With the assistance from various external support organisations, various community cadres were trained in the past and are working for the community. These cadres include, among others, Nutrition Promoters, Child Health Promoters, Traditional Birth Attendants (TBAs), Community Sanitary Workers, Peer Educators, Community-Based (family planning) Promoters, Community Health Promoters, and Community Health Workers (CHWs)[9]. According to the Health Act (1993), Neighbourhood Health Committees (NHCs), which exist per zone and per Health Centre catchments, are to function as overall coordinating body of the above-mentioned cadres, together with the supervision of the Health Centre.

2.37. Whether these cadres meet the demand of the community, and/or NHCs and community based organisations (CBOs) function in accordance with the vision of the Health Sector Reform is different depending on communities. If the activities of the Project are to be implemented, it is important to understand how these actors are functioning and engaging in activities and to analyse and plan how these existing structures can be utilised for provision of community-based health services.

2.38. *UNICEF* has been working for the betterment of infants and young children's lives in Zambia, through UNICEF-Zambia Country Programmes. Much work had been done under the Primary Health Care and Nutrition sub-programme as well as WASHE sub-programme in the last programme cycle (1997–2001). The former had four components: a) support to the Health Sector Reform, b) child health, c) nutrition, and d) mother and adolescent children. Child health component, in particular, is assisting malaria control activities in 50 districts and made achievement in the areas of ITN promotion, establishment of malaria sentinel sites, shift from

[9] Community health cadres, who are officially recognised by CBoH and supported and supervised by public administration, are limited to CHWs and TBAs only. The roles of CHWs are distinguished in rural and urban areas. CHWs in rural areas are provided drug kits and engage in simple medical treatment at health posts. In urban/peri-uraban areas, CHWs do not engage in such treatment nor health posts are established due to budget constraint.

chloroquine to coartem, tax exemption of ITN. Regarding HIV/AIDS, UNICEF assisted four technical working groups established at the central government level, MTCT prevention programmes in three districts including Lusaka district, HIV/AIDS education programme in North western, Lusaka, Central and Southern province. Nutrition project assisted provision of Vitamin A, supported legislation on marketing of breast milk alternative products and processing of food addictive, children growth monitoring at health centres and communities in eight districts.

2.39. WASHE sub-programme supported institutional building for the programmes combining water supply, sanitation and hygiene education in rural areas as well as direct assistance to WASHE at community level. Assistance to the central government was aimed to make efficient joint implementation by CBoH and MLGH of WASHE programme at province and district level. WASHE at community level focused on integration of HIV/AIDS issue and reduction of malaria and diarrhoea cases, targeting 320 schools and 1,000 villages in 15 districts. Major component of this sub-component was school health and integrated HIV/AIDS issue into curriculum and education material for grade 1-4 and 6-7 of life skill education and trained 90 teachers in three provinces. In addition, latrine construction for 1,000 households was assisted.

2.40. Under the new Country Programme (2002–2006), Primary Health Care and Nutrition sub-programme focuses on rural and peri-urban areas in a) improving IMCI services, b) community-based malaria prevention, c) community-based growth monitoring programme, d) immunisation, e) promotion of good infant feeding practices, f) provision of micronutrients, g) prevention of MTCT and youth-friendly and essential obstetric services. Under WASHE sub-programme, two components – school health and hygiene and community WASHE – will seek to reduce infant and under 5 morbidity and mortality through improving water and sanitation facilities as well as building caregivers and parents skills in child care. The sub-programme focuses on 13 districts in Eastern and Southern Provinces.

2.41. *USAID* regards Zambia as one of the priority assistance countries and has been extending its support to child survival in line with the Health Sector Reform as one of the three major programme areas. In the past, it was quite instrumental in introducing and establishing IMCI package in Zambia under BASICS. In 2002, USAID has a plan to provide US$ 21.6 million in support for a) expanded access to HIV/AIDS prevention services and treatment strategies, b) sustainable community-response mechanisms for orphans and vulnerable children, c) malaria prevention and treatment, d) reduction of vitamin A deficiency, e) immunisation services, f) prevention and treatment of diarrhoeal diseases, and, g) other child health interventions.

2.42. Through the *Zambian Integrated Health Package (ZIHP)*, USAID works hand-in-hand with CBoH to support health sector reform process. USAID is assisting 12 districts[10] for capacity building at NHCs and local NGOs as effective means of community participation and community-based health interventions. From the outset, ZIHP has the intention to develop a package for replication across the nation by applying knowledge and lessons gained from project implementation in pilot sites. ZIHP also effectively utilises research findings for their programmes and is developing IEC materials on child nutrition based on

[10] ZIHP targets both rural and peri-urban areas: Kalomo, Livingstone, Kabwe, Ndola, Kitwe, Chibombo, Kasama, Mwense, Samfya, Chipata, Lundazi, and Chama.

research results and the experiences of other interventions including JICA PHC project in collaboration with National Food and Nutrition Commission (NFNC). Outputs of this effort include curriculum/training guideline for CHW trainers[11], referral forms for CHWs, nutrition counselling card, "child's target weight card" to be distributed to mothers of underweight children, which are printed in 11 languages at maximum. ZIHP confined its role to overall technical advice and programme management with the purpose of strengthening capacity of Zambian local NGOs. Implementing NGOs and technical support NGOs are cooperating in project implementation at central and district level.

2.43. *CARE International* has been actively implementing many projects (18 projects as of February 2002) encompassing many sectors including child health and environmental health, which are also supported by CIDA and DfID. ***Project Urban Self-Help (PUSH-II)*** was implemented from 1992 to 1997 as a comprehensive community improvement programme (infrastructure development, training, and micro finance), targeting peri-urban areas in Lusaka and Livingston district and involving 2,000 women in the poorest quantile. Furthermore, CARE International implemented a large-scale project targeting 44,000 in Chipata and 40,000 in George, focusing on operation and management of water supply system by community-based organisations. Much effort was made to establish and strengthen the capacity of Resident Development Committee (RDC), which is under MLGH and Lusaka City Council.

2.44. Based on the experience of PUSH II, ***Programme of Support for Poverty Elimination and Community Transformation (CARE PROSPECT)*** is implementing three major components: organisational capacity building, infrastructure improvement, and training/micro finance. CARE PROSPECT aims to alleviate poverty by construction, rehabilitation, and operation and maintenance of water supply facilities, health and hygiene education, construction of toilets and drainage, and garbage collection. It also plans to include construction of education/health facilities and education to women organisations. The programme intends to strengthen community-based organisations to engage in such activities, particularly RDC and is cooperating with Livingston city council and Lusaka city council. It targets 14 compounds in Lusaka district totalling to the population of 600,000[12].

2.45. ***George Community Empowerment Project (GCEP)*** is JICA-funded project managed by CARE PROSPECT, which aims at building local capacity in, among others, water system subscription, community health and hygiene education and sanitation.

2.46. ***Moyo wa Bana*** (former ICMR: Infant and Child Mortality Reduction) deals with training on case identification of community cadres, training on case management and trainers of DHMT and health centre staff (based on IMCI manual developed in the past) and institution building. ***City Community Challenge Fund (C3 Fund)*** is a funding scheme for rendering support to community-based initiatives in Lusaka district, which is administered by Lusaka City Council. CARE International also works closely with other NGO partners such as Family Health Trust in Zambia and ZHIP, under SCOPE OVC (Strengthening Community Partnerships for the Empowerment of Orphans and Vulnerable Children), ZIHP-COMM (ZIHP Communications and Community Partnership) and ZHIPSERVE (ZIHP Service Delivery and

[11] "Facilitator's Guide for Trainers of Community Health Worker," ZIHP/CBoH, April 2000, Lusaka.
[12] These compounds include Chaisa, Chazanga, Chibolya, Chipata, Chuunga, George, Jack, John Liang, Kabanana, Kanyama, Mandevu, Matero, Mtendere and 4 Stones:Malota.

NGO Strengthening).

2.47. **JICA Primary Health Care Project** (1997–2002) has been assisting Lusaka District Health Management Team (LDHMT) to improve the overall health services provision, inclusive of preventative, promotional and curative components.

2.7.2 Water supply and sanitation facility construction programme

2.48. In the past, donor assistance has benefited water supply and sanitation in urban areas. *African Development Bank* (AfDB) financed work on the water supply and sanitation systems in Lusaka. *World Bank,* through IDA, contributed US$30 million for the Urban Restructuring Water Supply Project (URWSP) for repair and rehabilitation works for nine towns. *Japan* has also provided JP¥1,280 million under the grant scheme to water supply in selected unplanned compounds, and has aplan to expand into other areas in the future.

2.7.3 Various types of programs in coordination with LDHMT

2.49. A variety of partners including NGOs, CBOs, and public organisations have been implementing small-scale programs in Lusaka district. Its types are ranging from research and training to advocacy and service provision. The majority of research programs are related to HIV/AIDS. Training, advocacy, and service provision are implemented mainly at community level. Table 2.6 is a list of implementing organisations, target areas, and activities.

Table2.6 List of stakeholders, other health providers and Government Departments working together with LDHMT

No	Organisation	Area of Focus	Activities
1	Lusaka City Council	DHO All Health Centres	Public Health for the City (Prevention and Control of Diseases and Epidemics)
2	Arrakan Barracks - Under the Zambia Army	Army Health Facilities	Prevention and Control of Cholera
3	Prisons	Prisons	Control of Epidemics
4	National Maralia Control Centre	All Health Centres	Malaria Control Programme
5	Ministy of Community Development and Social Welfare	Railway, Kamwala	Provision of food supplements Street Kids Health Programme
6	Resident Development Committees	All Health Centres	Developmental projects Promotion of cleanliness in markets and residental areas
7	Neighbourhood Health Committees	All Health Centres	Health Education. Health Promotion. Identification of Health Problems.
8	Schools (MoE)	All Schools Health	Talks on personal hygiene, oral health check-ups. general physical screening. environmental health. HIV/AIDS awareness and prevention.
9	Bwefwano Home Based Care	Chipata Health Centre	Care of the terminally ill. home-based care activities. training of health care providers
10	Chelstone community-based Tuberculosis Organisation (CBTO)	Chelstone	Care of TB Patients - DOTS. Follow up of the defaulters. Training of Caregivers. Home-based Care for TB/HIV/AIDS. Provision of Laboratory Safety Cabinets. Integrated management of TB/HIV/AIDS.

No	Organisation	Area of Focus	Activities
11	Churches (Catholic Archdiocese	Kanyama, Bauleni, Chawama and Chipata	Care of the terminally ill
12	CHW/TBA	All Health Centres	Health Education and Promotion. Deliver uncomplicated deliveries. Timely referrals. Home-based care
13	Peer Educators (Youth, Adults)	All Health Centres	IEC. Distribution of condoms
14	Area Councillors, MPs, and other political leaders	All Health Centres	Advocacy. Resource mobilisation. Decision-making.
15	TICO	All Health Centres	Prevention and Control of Cholera. Provision of portable X-ray & Transport services
16	Lions Club	Railway, Chainda	Construction of Maternity Department
17	Ladies Circle Number One	Mandevu HC	Construction of TB shelter.
18	UNZA School of Medicine & Post Basic School of Nursing	All Health Centres	Consultancy, research and student attachments.
19	University Teaching Hospital	All Health Centres	Receives referred patients. Provision of Technical support. Nursing student attachments.
20	Chainama Hills College and Hospital	All Health Centres	Certificate Training in Public Health. Technical support.
21	Kara Counselling Trust	Matero Reference, Chawama, Kamwala, Mtendere, Chelstone	Training Health Workers in Counselling. Voluntary counselling and testing sites.
22	University of Alabama at Birmingham USA/Centers for Infection Control	Chawama, George, Matero Reference, Kalingalinga, Kanyama, Chelstone, Mtendere	VCT, PMTCT, Programs and HIV research interventions.
23	London School of Hygiene and Tropital Medicine	Mtendere, Matero Reference, Kalingalinga	Collaborative research on TB and HIV
24	CMAZ	All Health Centres	Training Health Workers in Post Abortion Care. Collaborative meetings with DHMT.
25	Zambart/Pro-test	Chawama, Chipata, Matero Reference	INH prophylaxis for HIV positive asymptomatic patients, screening and treating of STIs. Integration of Programme with MTCT, collaborative research
26	UNICEF	All Health Centres	RPR testing. Mother Support groups (Breast feeding and nutrition). Youth friendly activities training of Health Workers, Peer Educator and the Community.
27	Mother Teresa's Home	Mtendere	Clinical care. Nutrition.
28	SFH	All Health Centres	FP. Water purification through provision of chlorine for revolving funds. Promoters of Budiza, provision of ITNs for revolving fund.
29	Linkages	Mtendere	Promotion of VCT, Pre- and Post-test counselling.
30	Zambia Counselling Unit	Mtendere, Matero Reference., Chawama	Promotion of VCT, Pre- and Post-test counselling.
31	Institute of Child Health, University College of London	Chilenje	Collaborative research

No	Organisation	Area of Focus	Activities
32	Center for Disease Control	Chilenje, Chelston, Matero Reference, Chawama	Surveillance of infectious diseases
33	Central Statistical Office	Catchment populations of selected HCs	Demographic and Health Survey
34	Environmental Council of Zambia	DHMT	Malaria control, promotion of safe environment
35	National AIDS Council	DHMT	STI/AIDS Activities
36	University of Colombia - Zambia Exclusive Breast-feeding, Boston University	Chawama & George	Nutrition and breast feeding
37	National Institute of Health/ U.S. Government	George, Chawama, Matero Reference, Kanyama, Kalingalinga Clinic	Construction of counselling and consultation rooms. Construction of Central Lab and upgrading of District Lab Technicians. Research Interventions.
38	institute of Child Health, University College of London	Kanyama, Matero Reference, Kalingalinga	Research - Antibiotics to Reduce Choriomnionitis-related Prenatal HIV transmission.
39	Elizabeth Claser Paediatric AIDS Foundation, DHMT	Mtendere, Chelston, Matero Reference, Kanyama, Kalingalinga	Training of midwives in VCT. Administration of Nevirapine.
40	Fogarty International, UTH, DHMT	Matero Reference, UTH	Midwives ToT training, Midwives training
41	UAB, Bill and Melinda Foundation, DHMT, UTH	Lusaka	Detailed assessment of necessary data elements and functional requirements of an electronic perinatal medical record system. Electronic Perinatal Record System to be improved.
42	National Institute of Health/ U.S. Government	UTH, All Health Centres	HIV Therapeutic Research.
43	UNICEF	UTH, Chipata	PMTCT. Provision of AZT and formula. Controlled cohort.
44	UAB/USA, National Institute of Health	Matero Reference, Kanyama, UTH	VCT for couples in Prenatal Settings, PMTCT, Programs and HIV research interventions.
45	Boston University, Columbia University, University of Alabama at Birmingham, National Institute of Health/USA	Chawama, George, UTH	Research on likelihood of Post Natal MTCT through Exclusive Breast Feeding Program, on the magnitude of increase in non-HIV related under 2 year mortality attributable to cessation of breastfeeding at 4 months, development of culturally acceptable and sustainable breast feeding community education program based on the above research result
46	---	Chilenje Health Centre and UTH	KAP of infant feeding among mothers and fathers, measurement in Zambia 9-month-old infants and relate to infant feeding practices

Source: LDHMT Action Plan for the Year, 2002.

3. Problem to be addressed: the current situation

Following the description of the institutional framework of the health service system in general and Lusaka District in particular, Chapter 3 identifies "***high morbidity and mortality of children***" as the core problem to be tackled by the Project. The analysis further identifies the causes at ***family/community***, ***health centres***, and ***LDHMT*** as leading to the core problem. There are five factors at *family/community level* negatively influence childe health: ***malnutrition***, ***late case recognition***, ***poor environmental health***, ***poor child care***, and ***HIV/AIDS***. These factors contribute to prevalence of *diseases* among children, namely, ***measles***, ***diarrhoea***, ***malaria***, and ***ARI***. Despite this prevalence, *health centres* are ***unable to manage the cases appropriately***. *LDHMT* has ***difficulty in supporting community based health activities***.

3.1 Institutional framework for the health sector in Lusaka District

3.1. The section reviews the institutional framework of the health care services in Lusaka District with reference to (1) institutional framework of the health care service system and (2) Lusaka District Health Management Team (LDHMT).

3.1.1 Institutional framework of the health care services

3.2. The structure of health care services is characterised by two parallel structures: (1) popular representative structure (Neighbour Health Committee, Health Centre Committee, District Health Management Board, and Hospital Management Board) and (2) technical structure (District Health Management Team, Hospital Management Team, and MoH/CBoH). The health care service delivery system is defined in the National Health Strategic Plan.

Table 3.1 Type and function of health facilities and organisation

Type	Function
Health posts	One health post is established per 500 households/3,500 people in rural areas and 1,000 households/7,000 people in urban areas to cater the service of health post package of care and outreach activities.
Health centres	The health centres in urban areas cater its service for a catchment population of 30,000-50,000. In rural areas, a population of 10,000 or an area of 29 kilometre radius is covered by a health centre. The services of health centre include normal delivery, basic inpatient services in addition to the predetermined package of care.
District/First level referral hospitals	The institution is the first level referral of care with outpatient and inpatient services with the specialities of surgery/obstetrics, medicine/paediatrics, basic laboratory/X-ray, serving a population of 80,000-200,000
Second level referral service (General hospital)	The hospital is a service provider of OPD, internal medicine, general surgery, gynaecology/obstetrics, dental, psychiatry, paediatrics, expanded laboratory/ X-ray, and training of medical staff, with a catchment area of 200-800,000 population.
Third level referral service (Central hospital)	Central hospital is the third level referral of care with specialised medical care and teaching hospitals, serving a catchment population of 800,000 or above. The services include OPD, general surgery, gynaecology/obstetrics, internal medicine, paediatrics, ICU, laboratory and X-ray department, research department, and training of medial staff.
Ministry of Health/Central Board of Health	Ministry of Health is mainly responsible for policy guidance and strategic planning. Central Board of Health, on the other hand, implements the government's health policies.

Source: Joint Identification and Formulation Mission for Zambia (2000)

3.1.2 Lusaka District Health Management Team

3.3. LDHMT is responsible for the operation and management of the health services of Lusaka District and assigned the following functions.[13]

1. Provide managerial and technical support to health centres and 1st referral hospitals;
2. Mobilise and distribute resources to health centres and 1st referral hospitals;
3. Provide training to staff in health centres and 1st referral hospitals;
4. Lead and coordinate the work of NGOs and other stakeholders in the District; and
5. Analyse district information and provide feedback to health centres.

3.4. LDHMT has its headquarters, 24 health centres, a few health posts, and other facilities[14]. Among 24 health centres, four centres are expected to function as first referral institution[15]. Although University Teaching Hospital (UTH) is the third level referral institution, due to an absence of the second referral level institution in Lusaka District and limited functions of the health centres, UTH receives the patients who are referred by health centres or used to bypass the centres until it started to charge fees for self referral.

3.5. The staff allocation does not meet the standard, particularly at health centre level. The number of the staff at LDHMT is 73, whilst the required number is 80. The total number of health centre staff is 1,444, whose figure is 333 less than staffing requirement.

3.6. LDHMT's revenue is expected to reach up to ZK12,597 million in 2002, an increase by 67.8% from the previous year, though it should be noted that the disbursement of the central government grant tend to delay and fail to meet the approved budget amount. The budget of DHMT has 10% ceiling on capital investment, which makes it difficult for LDHMT to renovate and construct health centres.

Table 3.2 Estimated revenue and expenditure of LDHMT in 2002

(Unit: ZK million)

Revenue			Expenditure		
Item	Amount	%	Item	Amount	%
Grant	11,614.3	92.2%	Community	289.0	2.3%
User fee	983.3	7.8%	Health centres	8,688	69.0%
			1st level hospital	2,497	19.8%
			District Health Office	1,124	8.9%
Total	12,597.6	100.0%		12,597.6	100.0%

Source: Lusaka District Health Management Board, Action Plan for the year 2002

3.7. Drug purchase and procurement is critical for health care service system. Drug supply is procured and supplied by Essential Drugs and Medical Supply Store (EDMSS) at the central

[13] Zambia National Health Strategic Plan 2001-2005 Joint Health (Pre)Appraisal Mission, Final Report. May 2001

[14] See Annex 8.8 for the organisational structure of LDHMT and Annex 8.9 for the list of health centres with functions.

[15] Chelstone, Matero Reference, Kanyama, and Chilenje are expected to function as 1st referral institutions.

level. The erratic distribution of drugs, combined with shortage of equipment supply, forces LDHMT to spend the budget for Emergency Drugs and Supplies Expenditure beyond 4% of the budget, which is the ceiling of the item.

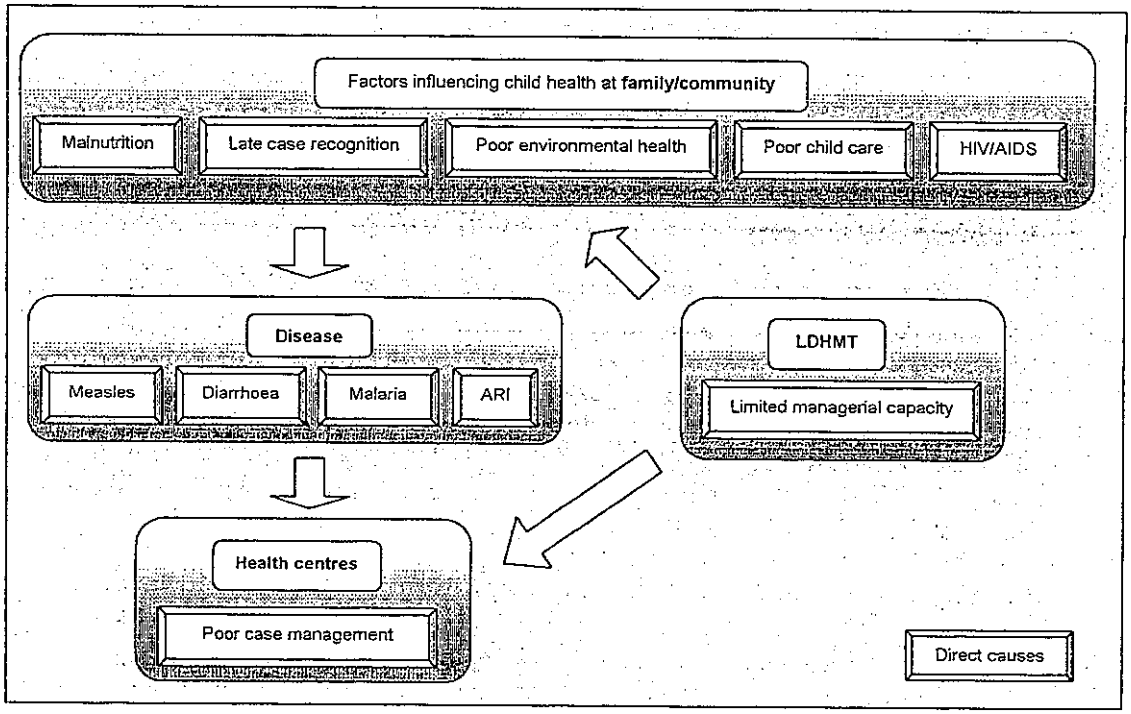
3.2 Problem to be addressed: the current situation

3.8. This section first identifies the core problem to be tackled in the health sector in Lusaka District. Causes underlying the core problem at different levels are then discussed and analysed, implying that the Project's interventions accordingly address different actors and factors.[16]

3.2.1 Core problem and underlying causes

3.9. Through the analysis, the core problem is identified as "**high morbidity and mortality of children**". Although the priority of direct causes leading to the core problems is not decided, they can be summarised based on actors involved and causal relationship.

Diagram 3.1 Problems on child health at family/community, health centre and LDHMT level



3.10. Factors at *family/community*, *health centres*, and *LDHMT* are intertwined, causing high morbidity and mortality among children. There are at least five factors at *family/community level*, which significantly and negatively influence child health: **malnutrition, late case recognition, poor environmental health, poor child care,** and **HIV/AIDS**. These factors contribute to prevalence of *diseases* among children: **measles, diarrhoea, malaria,** and **ARI**.

[16] Problems analysis in this section is mainly based on (1) Project Cycle Management (PCM) workshop and (2) institutional and organizational analysis workshop.

Despite this prevalence of diseases and resultant high mortality, *health centres* are **unable to manage the cases appropriately** due to a variety of reasons. *LDHMT*, as the management organisation of the health services in Lusaka District, has **difficulty in managing the services adequately and supporting community based health activities** as a result of bottlenecks, which is explained in 3.2.5.

3.2.2 Factors influencing child health at family/community level

3.11. Factors leading to the core problem (morbidity and mortality of children) are further affected by multi faceted factors.

Malnutrition of children

1. *Enough food is not available in household* due to the poverty prevalent in the compounds.

2. *Caretakers do not feed children properly* as they do not have enough knowledge or they are influenced by traditional beliefs.

Poor water and hygiene condition

3.12. Although water and hygiene conditions are not identified as a direct cause of the core problem, this factor indeed has multiple and significant impact on prevalence of diseases as is explained as contributing factors to malaria and diarrhoea. In Lusaka District, percentage of population with access to safe water supply is estimated 60%. Garbage collection of LCC is limited to business centres.

Increased incidence of HIV/AIDS

3.13. HIV/AIDS has two different negative impacts on child health. The first is the prevalence of AIDS among children because of *mother to child transmission*. AIDS is the fifth rank in under-5 children' deaths in 2000 in Lusaka District. The second aspect of HIV/AIDS is poor child health care due to *orphanage* resulting from death of caretakers or their frequent illness.

Poor child care

3.14. Poor child care is caused by *limited knowledge on child care* and *teenage pregnancy*, as well as illness and death of caretakers due to HIV/AIDS and other diseases. Poor knowledge and care to child leads to late case recognition on child's illness by caretakers.

Late case recognition

3.15. *Caretakers do not have enough health knowledge*, resulting in late case recognition of children, leading to late referral to a health centre and high case fatality rate. This is caused by any or a combination of inactive health information provider (NHC, CHWs, etc.), limited access to media, belief in tradition.

3.2.3 Priority diseases of children

3.16. The factors described above lead to high incidence of the diseases among children.

Malaria

3.17. Health data of LDHMT proves that Malaria is the top killer of children in Lusaka District. This is caused by a combination of several factors.

1. *Vector control is not properly conducted* because of limited funding of the government agencies and lack of community participation.
2. *Drainage facilities are not well developed and maintained* due to limited funding and community contribution.
3. *The utilization rate of insecticide treated net is low* either because it is unaffordable or unavailable.
4. In addition to poor hygiene condition in the compounds, *cases of malaria are poorly managed* and *rapid development of resistance to affordable chloroquine*
5. *High rate of urbanisation* leading to unplanned housing and development, which results in poor hygiene conditions
6. *Changing climate pattern* favourable to mosquitoes

Measles

1. *Children are not appropriately vaccinated* due to poor management of cold chain, erratic supply of measles vaccination, syringes, and needles, community's lack of recognition on the importance of immunization. Coverage ratio of measles immunisation is 59% in 2000 in Lusaka District, whilst those for BCG, OPV3, and DPT3 are 76%, 78%, and 86% respectively.
2. *Children's immunity is adversely affected by malnourishment.*
3. *Housing condition further exacerbates children's immunity* as a result of high fertility and small house plot, which results in congestion in the house.

Diarrhoea

1. Many people in the compounds *use contaminated water* as they can not afford safe water or due to a lack of knowledge on treating water. Contaminated water leads to diarrhoea particularly among the vulnerable group, children.
2. Absence of proper garbage collection and disposal, inadequate vector control, poor conditions of toilets all contribute to *the increased number of vector and rodent*, which in turn contaminates water and food, leading to diarrhoea.

ARI

3.18. Prevalence of ARI increases in *cold weather season* from June to July, dusty season from August to October. Furthermore, *low immune status* combined with *malnutrition* and *overcrowding in the house* contributes to high prevalence of ARI.

3.2.4 Health centre level

Poor case management

3.19. Health centre is the entry point of medical services to the compound residents. At this level, factors negatively contributing to case management capacity at health centres are many. *Low skill of health centre staff, poor case history from caretakers, inadequate medical equipment and drug, congestion of health centres, and lack of integrated health care services*

are some of these factors identified.

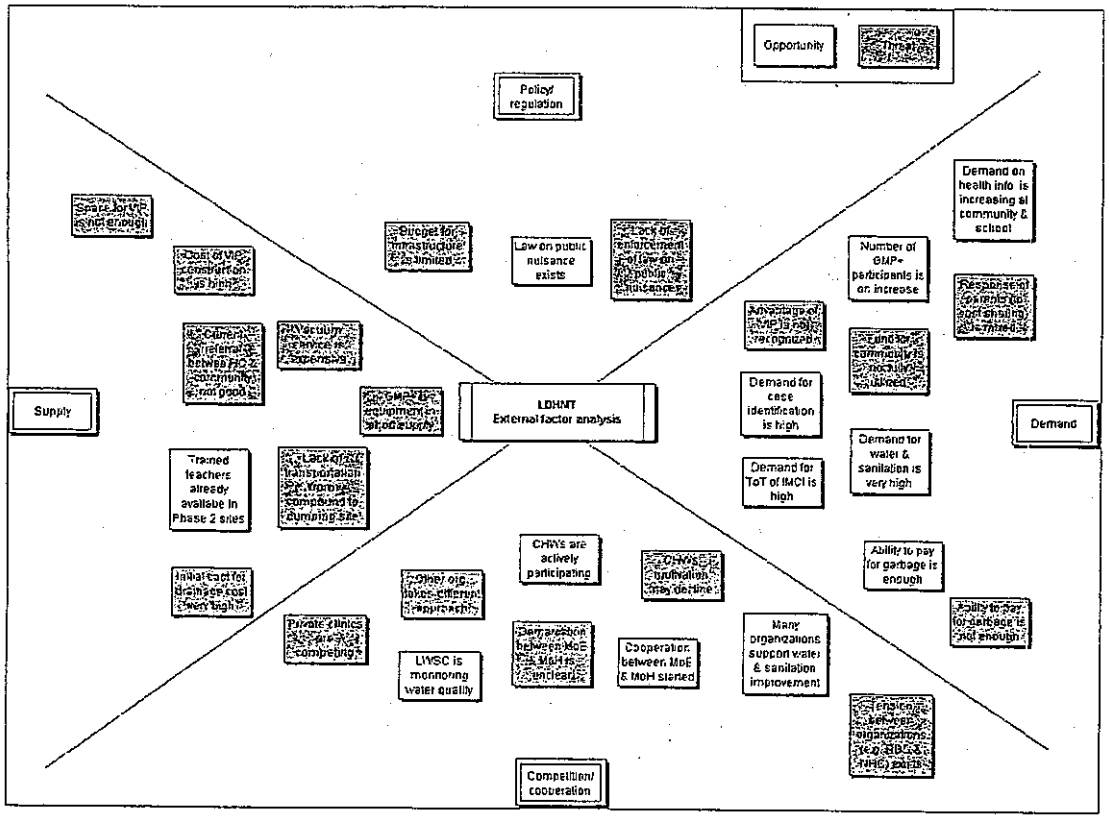
3.2.5 LDHMT level

3.20. Although the issue of LDHMT's capacity and roles was not explicitly discussed in the PCM workshop, factors within and outside LDHMT are analysed here to complement the problems analysis of the health sector in Lusaka District, which is described in 3.2.1 to 3.2.4 and to identify *strengths* and *weaknesses* of LDHMT and *opportunities* and *threats* in the surrounding environment.[17] The result of the analysis is incorporated into the strategies and activities for capacity building of LDHMT to support health centres and CBOs, which are detailed in 5.2.2 and 5.2.3.

External factor analysis

3.21. Factors in the external environment are analysed with reference to four typical issues: demand, supply, policy/regulation, and cooperation/competition.

Diagram 3.2 External factor (opportunity & threat) analysis of LDHMT



3.22. The *demand* for community-based health care service and water/sanitation service is high, implying that LDHMT's services in this area would be in high demand if they are of high

[17] The analysis in this section is based on the outcome of the discussion in the workshop with LDHMT staff.

quality and efficient.

3.23. Despite the existence of huge demand, it is unlikely that LDHMT can offer the above-mentioned services as *supply and allocation of the resource* is limited due to the fact that the primary responsibility of infrastructure development such as water and sanitation rests with Lusaka City Council.

3.24. In *policy/regulation* area, an absence of law enforcement on public nuisance is identified as a threat. It has a risk that LDHMT's effort to tackle this issue may be hindered by lack of law enforcement. According to LDHMT, efforts are being made to have Lusaka City Council delegate this activity to LDHMT.

3.25. Regarding *competition/cooperation* with other actors, the picture is mixed. Decline of CHWs' motivation is regarded as a potential threat to community-based health activities due to heavy workload, lack of recognition and/or lack of appropriate incentives, though it is the major driving force of the activities.

3.26. Ministry of Education (MoE) embarked on the comprehensive program on school health and nutrition under the Basic Education Sub-Sector Investment Programme (BESSIP). Thus demarcation of MoE and MoH/CBoH is not clear in school health though the latter is providing technical assistance to the former's program.

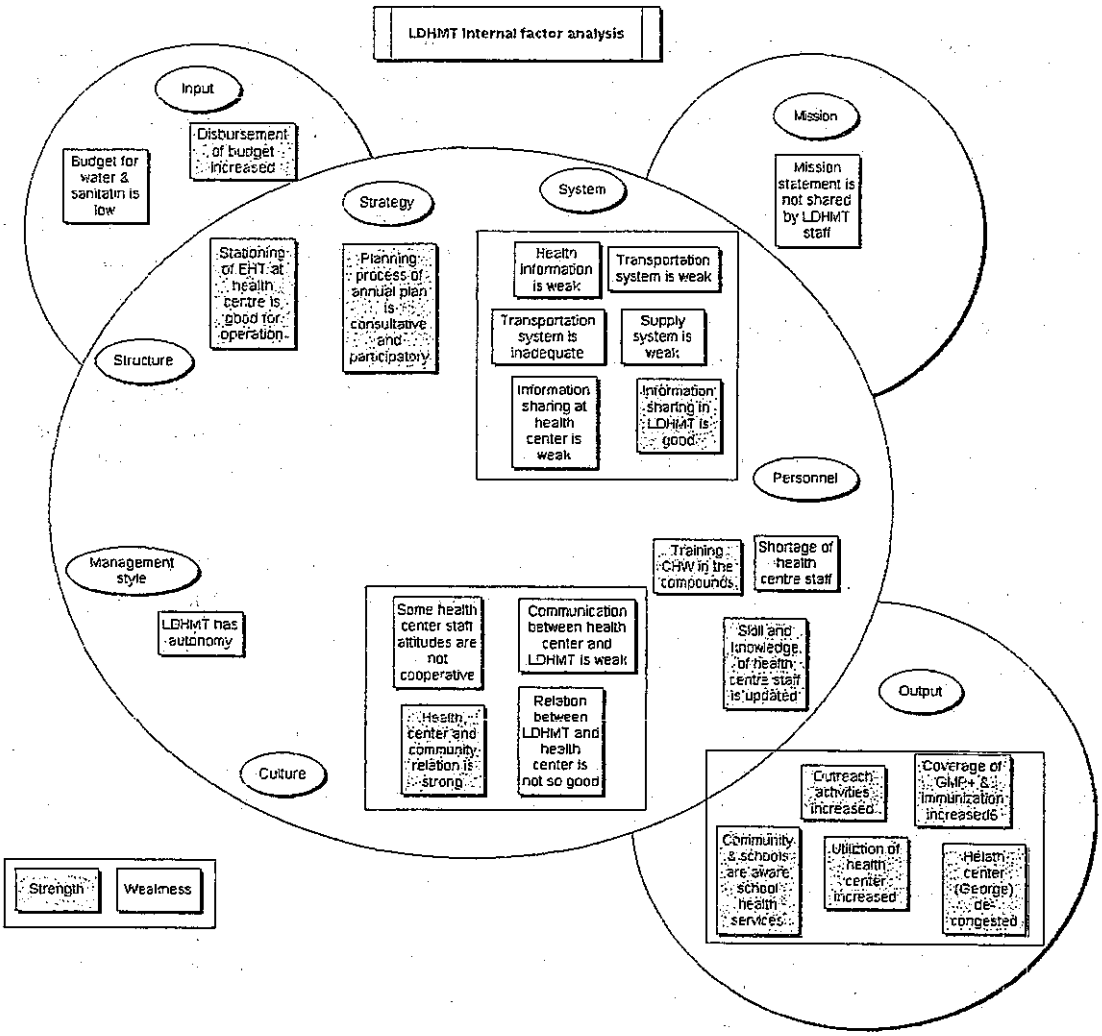
3.27. Some NGOs (e.g. CARE International), who are also working in some of the compounds, may be taking different approach in their community-based health projects. It is worthwhile looking at the similarity and difference and identifying measures to accommodate the difference and avoid potential risks.[18]

Internal factor analysis

3.28. Factors inside the LDHMT are analysed here to assess strengths and weaknesses. It specifically focuses on critical factors in the organization.

[18] See *4.4 Special consideration* for the discussion of this issue.

Diagram 3.3 Internal factor (strength & weakness) analysis of LDHMT



3.29. The analysis of internal factors within LDHMT shows some major strengths and weaknesses.

1. Weak communication and relationship between LDHMT and health centres
2. Weak management system (transportation, drug and equipment supply, health information)
3. Low possibility of investing in infrastructure development (e.g. health centre renovation and construction)
4. Expansion of community based health activities as a major output

Implications of external and internal factor analysis

3.30. From the result of analysis of internal and external factors, it can be assumed that LDHMT has produced significant outputs in community based health activities, meeting the demand in the compounds despite its major organisational weaknesses such as weak management system and communication and cooperation with health centres. The issue to be

examined here is why this was made possible. It can be inferred that the achievement in community health activities may have been heavily dependent on the effort of CBOs and health centres as the strong ties between them is identified as strength of LDHMT and also confirmed from the field survey conducted. In other words, there is much room for LDHMT to strengthen its capability, which in turn enhance the activities in the community through improved support to health centres and CBOs.

4. Project strategy

The Project's ultimate vision is to establish a sustainable community-based structure for community cadres to provide essential health services. ***Sustainability measures*** are the central concern of the Project Strategy. Emphasis will be placed on effective use of ***participatory tools and processes triggered thereby***. Another sustainability measure is about ***establishing effective and systematic link*** among policy makers, health management, service providers and service recipients.

4.1 Project strategy

4.1.1 How the Project tries to achieve the vision

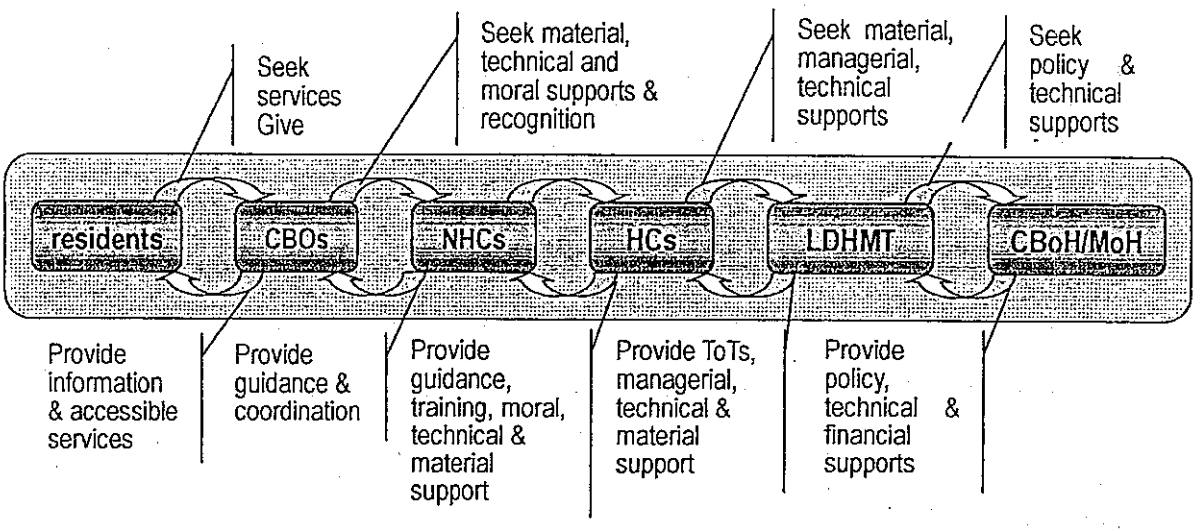
4.1. This Project, in summary, is ***an attempt to curve downward trends of health status of infants and children under 5 years, through expanding and sustaining knowledge base and capacity of the people***. Poverty-stricken communities in unplanned urban settlements are focus of this Project. As such, the Project will emphasise more on preventative and promotional aspects of health services provision than on curative aspects, averting burdening of the poor with health-related expenses.

4.2. The key question, and also a major challenge of this Project, is how community's motivation to provide and manage health-related information and services can be created, supported and sustained after capacity is built among community cadres and CBOs. This is especially exigent in urban setting, where there is an inevitable diversity among neighbouring residents, and cohesiveness or solidarity among community members is weak or difficult to develop.

4.3. Phase I of the Project was able to overcome the said difficulties, through training of CBO members and Health Centre staff, together with long-run follow-up supports by the Project experts. However, the achievements in turn invited inflated demand and higher expectation from beneficiaries, putting a good deal of stress on CBOs and Health Centre staff. For the CBO members to respond to such demands, therefore, more substantive support from the management is required.

4.4. In order to address this aspect, Project interventions will try to emphasise ***establishing effective and systematic link*** between health management and beneficiaries. Capacity building will not only concentrate at the community level, but involves actors at various levels, in order for different actors to be able to perform their parts. These actors include community cadres such as Community Health Workers and Nutrition Promoters, other CBOs, Health Centre staff providing support for CBOs, as well as LDHMT providing technical backstopping to Health Centres.

Figure 4.1 PROJECT STRATEGY: Strengthening essential Linkages between different levels...



4.1.2 Institution building ~ building capacity at various levels

4.5. *Community members.....* This Project will place utmost importance on community participation. The term community participation, in this context, embraces two meanings. One is that members of the community is trained, mobilised and supported to plan, implement and manage community-based health activities. The other is that incentives required for selected members of community to provide services are, to the extent possible, generated at the community level. There are observed willingness or hope among the members of the community to improve living environment they are surrounded by, indicating that there are some opportunities for social mobilisation.

4.6. *Community-based organisations.....* . The Project will seek ways in which various community cadres, especially CHWs and Nutrition Promoters, can continue to play instrumental roles in health education, social mobilisation and community-based services provision. Motivation level among community cadres is quite essential in this context. Thus, the Project will pilot self-sustaining income generating venture, in the form of health facilities run by CBOs, as a way to generate incentives for community cadres[19]. For such community-based activities to be sustained and its quality maintained, proper recognition and moral support from the health authorities combined with monitoring and management by capable bodies are required. In this regard, the Project will facilitate strengthening of a coordinating and monitoring body, e.g. NHC, CHWs, Resident Development Committee (RDC), and/or Health Centre, which is in position to assist community cadres, and its managerial capacity to be built.

4.7. *Health Centres.....* The above-mentioned efforts at the community levels entail close

[19] Please refer to *Annex 8.7 Matters to be considered: suggested health facilities in a community* for more information on this initiative.

supervision, moral, technical and material supports by a health institution located in a community. The Project will also support capacity building in leadership/supervisory skills for relevant Health Centre staff. Regular reporting to and negotiation in particular demands with the LDHMT are among crucial function to be played at this level.

4.8. *LDHMT*..... Each Health Centre is surrounded by catchment areas with different environment and conditions, which may make standardised institutionalisation of community-based health services provision quite difficult. As the same time, considering the fact that community participation is such a fragile entity, one cannot emphasise enough how systematic and stable support from the management/administration is indispensable for its survival. Therefore, Project interventions to these several Health Centres need to be closely monitored and supervised at this level, for technical backstopping, moral and material support, as well as facilitation of potential cross-fertilisation of lessons learnt from different catchments.

4.1.3 Capacity building, follow-up support, self-reliance building as a package

4.9. In the past, many community capacity building ventures in the form of intensive trainings could not secure sustained effects, spreading too thinly at the community-level. Some argue that it is due to managers' inability to follow-up on training activities, and/or mere shortage of funds/technical supports to implement follow-up activities. Others attribute the failure to insufficient coverage of curriculum and/or to the lack of confidence among the trainees to practice what they acquired.

4.10. In order to overcome such hurdles, the Project intends to take stakeholders, especially those at the community level, the way through a course of self-reliance building:

① Participatory needs identification and action planning, such as Participatory Planning and Action (PLA) tools and Participatory Hygiene and Sanitation Transformation (PHAST), will be applied in order to promote community participation;

② Community action plans emanating from such process can be initially supported from the Project resources in terms of financial, material, and technical inputs, in order to build confidence and maintain motivation among the members for community autonomous activities; and

③ Activities promoting self-reliance, such as skills development in project planning and proposal writing, financial, institutional management and democratic leadership skills need to be introduced in a timely manner.

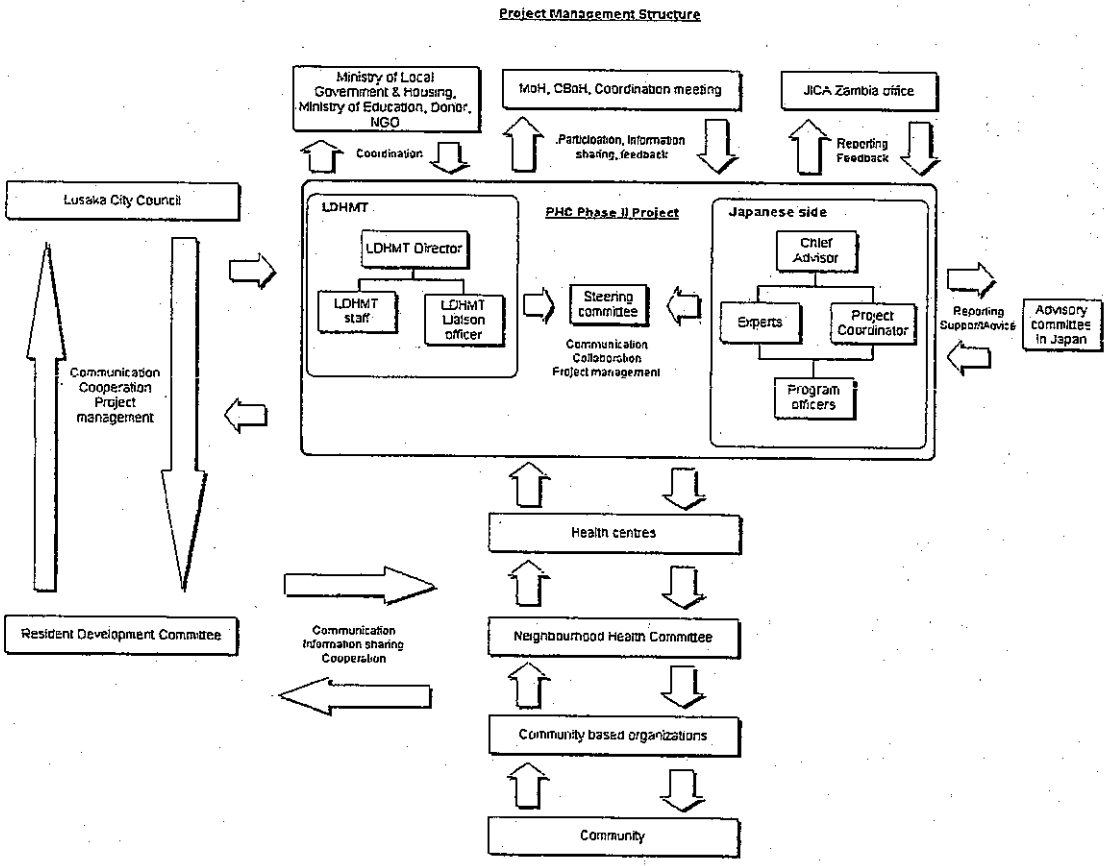
4.11. Technical cadres from the health system shall also be equipped with skills and confidence in order to provide continuous supports to the community cadres. Again, establishing effective and sustainable cost recovery and incentive generation mechanisms will be an integral component of the Project.

4.1.4 Targeted entry points to the community

4.12. In the Planning Workshop carried out using the PCM method, the participants identified both environmental health and growth monitoring promotion plus (GMP+) combined, to be the most pertinent issues to be dealt with by the Project. The Project will consider the

above two issues concerning child health as targeted entry points to the community: environmental health and monitoring of childhood illnesses. Priority given to these two areas is high, as mostof mortality and morbidity are caused by water-borne and vaccine preventable diseases. Equally, strong demand and interest in these two areas by community members are observed, indicating that they can serve as stimulants to active participation by the community members. Information, education and communication (IEC) activities are considered to be cutting across the different components of the Project.

4.2 Implementation arrangements

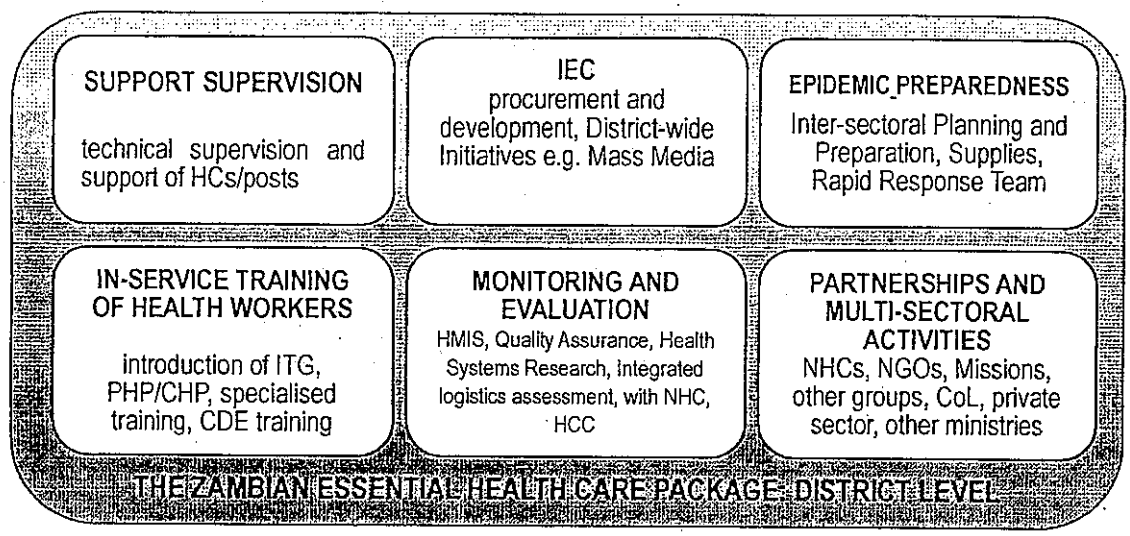


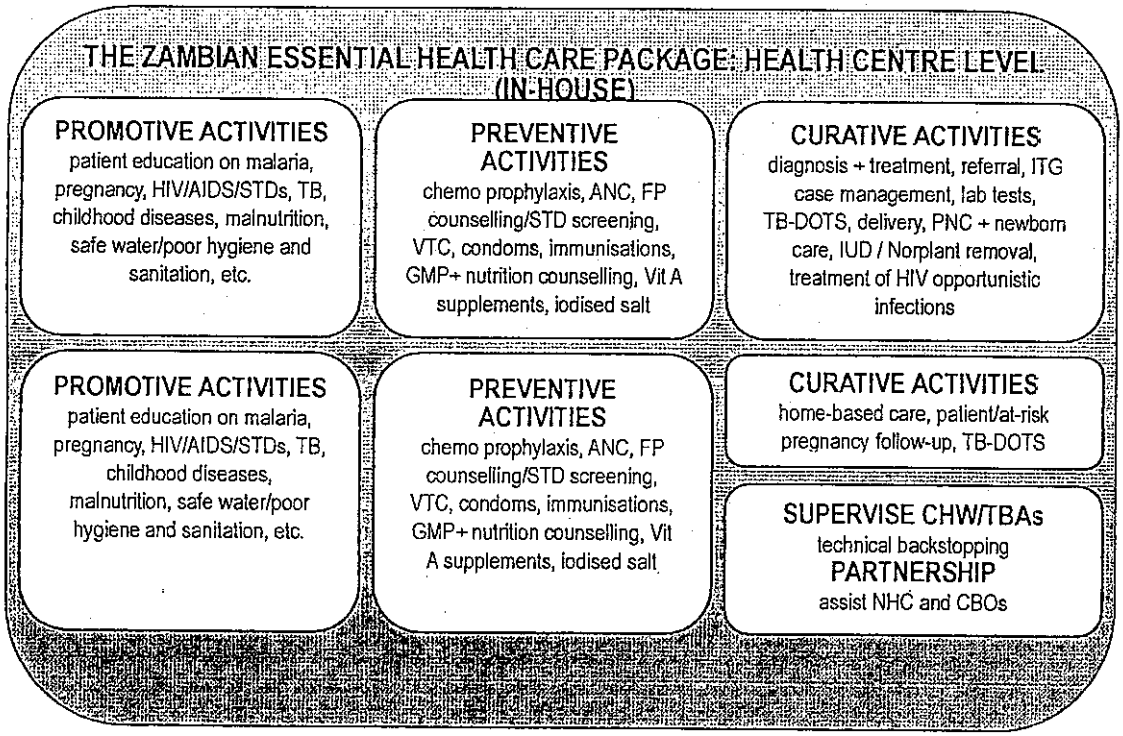
4.2.1 Counterpart Organization

4.13. Lusaka District Health Management Board (LDHMB), together with Hospital Management Board, is responsible for the provision of a basic package of health care to the people of Lusaka. At the same time, the Board is to carry out primary health care activities to plan for and implement health promotion and preventive activities. Twenty four (24) Health Centres in Lusaka District, among which several Health Centres will be drawn as Project sites, are under direct supervision of the Board, and its operational arm, LDHMT. Components of essential package to be provided at the district level, and at the Health Centre level (in-house and outreach) are shown in below boxes.

4.14. Areas of intervention that is dealt with in the district health system include, but not

limited to: 1) Information, Education and Communication; 2) Reproductive Health; 3) HIV/AIDS and STDs; 4) Child Health; 5) Malaria; 6) Tuberculosis; 7) Clean Water, Hygiene and Sanitation; 8) other integrated PHC activities; 9) Training, Supervision and Support; and, 10) Partnerships.





4.15. In the course of almost a decade-long Health Sector Reform, much authorities in determining particular contents of the service package are given to the DHMT level, so far as decisions made at this level does not contradict with the MoH/CBoH policies, guidelines, and

rules and regulations[20]. As such, the LDHMT will hold managerial and implementation responsibilities of the Project.

4.2.2 Project advisory and management structure

4.16. An advisory committee will be set up in Japan to provide necessary technical support and overall advisory to the Project, as and when needed. In case the Project requires much timely policy/technical backstopping, relevant local technical forums may be consulted (please refer to the next section for more information). In addition, it may request through JICA Zambia Office such assistance from a technical advisor who will be designated in the Ministry of Health.

4.16. The Project will also require a management/steering committee that will guide and supervise the process of planning, implementation, monitoring and internal evaluation of the Project. Quarterly steering meetings can be held to discuss specific Project matters. The committee may also be represented from members listed under the "Person in Charge" column in the Plan of Operations, assisted by the Chief Advisor and other JICA experts. In view of the fact that functioning weekly management meeting is in place within the LDHMT, and with the interest of collaboration and coordination among different LDHMT projects, it is also suggested that the Project may refer its day-to-day managerial/supervisory matters to the existing committee, and JICA Project staff to be providing a member(s) to the meeting.

4.17. In terms of the financial execution, JICA Project Coordinator is expected to collaborate closely with the LDHMT administration. Financing arrangements, including cost sharing, will be a result of careful discussions between the two parties.

4.2.3 Coordination with other relevant organisations

4.18. Whilst key issues addressed in the Project such as nutrition and environmental health require multi-sectoral approach that involves the MoH/CBoH, MoE and local authorities under MLGH, programmatic and technical coordination among different ministerial bodies has been weak, both at national and district levels (JIFM, 2000). Notwithstanding, management of the Project may require technical and policy-level consultations and advises from the central administration, as it contains new initiatives, e.g. piloting health facilities or health posts in urban settings. The management can also benefit from experiences in other districts, which have similar challenges and initiatives.

4.19. Thus, for the purpose of exchanging information and views among other similar projects/programmes, the Project, represented either by a management member or Japanese experts, will actively participate in both national and district-level forums concerning child health and environmental health. Relevant forums include, the Inter-Agency Coordination Committee on Child Health (IACC-CH)[21], meetings facilitated by the Programme Coordination

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[20] Despite its *de jure* autonomy, there is a general tendency where DHB/MTs through Provincial Offices often consult matters that may not require approval at the higher level, but that may need attention and advise from central level.

[21] Inter-Agency Coordination Committee on Child Health functions as a national-level body to monitor different child health projects/programmes, as well as plan, run and manage occasional joint activities.

Unit (PCU)[22] under the Ministry of Energy and Water Development, as well as other appropriate district-level coordination committees concerning child health and environmental health[23]. Various coordination activities with concerned governmental and donor agencies that require central-level discussions can be dealt with at this level.

4.20. At the same time, the Project will require a forum for much more involved technical and policy-level discussions. In this regard, the Project can both contribute to and benefit from taking part in a forum such as the Nutrition sub-group under the IACC-CH, and other similar technical forums. If there is such a need, establishment of a technical forum at the district level may be considered by the Project management.

4.3 Special consideration

4.3.1 Inter-sectoral coordination on environmental health

4.21. It is observed that there are potentially unhelpful segregation and/or duplication of efforts made by two vertical structures in the area of environmental health. One administrative line comes from the MLGH through local councils down to the registered RDCs[24], whilst the other line flows down from the MoH/CBoH to NHC[25]

4.22. General demarcation is that the institutions under the MoH structure deal with promotional functions of water and sanitation area, as shown in Box 4.1, whilst those under the local authorities take charge in supply of piped water, management of Water Committees in localities, management of excreta and liquid waste disposal as well as solid waste disposal.

Box 4.1: Water and Sanitation related interventions by institutions under the MoH:

- ✓ provision of health education in schools and communities on clean water, hygiene and sanitation
- ✓ promotion of community actions to protect water supplies and encourage construction of latrines
- ✓ provision of technical assistance to community-initiated projects on latrines, protection of water source, and well construction
- ✓ improvement of health facilities, and, testing of water samples for reporting to the LWSC

4.23. Confusion tend to occur at community-level, where there are overlapping, if not

[22] PCU is an inter-ministerial committee, which meets every quarter and functions as a discussion forum on all issues of water supply and sanitation.

[23] District Development Coordination Councils (DDCC) are to coordinate multi-sectoral development programmes in their locality. Nevertheless, this system functions in some locality whilst in others separate coordinating bodies beyond DDCC are created (JIFM, 2000).

[24] RDCs, under the Societies Act, are legal entities charged with coordinating development activities at the settlement level.

[25] NHCs, established under the Health Act, are legal entities charged with coordinating health-related community-based activities as well as organisations/groups at zone/unit and catchments levels.

competing, roles between RDC and NHC to coordinate and support community-based groups working on garbage collection, latrine and drainage construction, as well as daily management of the public and private water taps. This particular issue also relates to the need for coordination and potential collaboration with other donors supporting local authorities such as CARE projects.

4.24. In order to address this issue, there are policy-level discussions under way on potential administrative changes that involved the MLGH structure, which scope include coordination structure with the MoH[26]. As potential confusion, if not division, among community members and community-based organisations can be a threat to positive process of community participation and transformation, the Project Management should carefully monitor development of this policy dialogue. Open dialogue between these different sectoral institutions at national, district and community levels need to be facilitated in order to come up with adequate coordinating structure.

4.3.2 Incentives to community-based organisation

4.25. Under Phase I of the Project, monetary and in-kind incentives did play a major role for the CHWs to work harder and longer hours. However, we have also come to learn that discontinuation of incentives had major negative effects on CHWs, e.g. de-motivating their active participation, accumulation of frustration, etc. Also learnt was that non-monetary incentives, especially intangible ones given in the form of recognition by the health authorities as well as appreciation by the community residents, were quite essential, if not sufficient for drawing voluntary contributions from CHWs. Thus, incentive provision, whether monetary, in-kind or intangible, should be carefully examined before their introduction, as it has a potential to create dependency on a provision which may not continue after the Project's termination, or even to spoil thriving volunteerism[27].

4.26. As an integration of incentives into recurrent budget of LDHMT may not be realistic at this stage, incentives should be generated at the community level. Sustainability of incentives needs to be sought from the planning stage. Initial support from the Project to manageable and profit-making activities may be advisable.

4.27. The Project considers an option of institutionalising a provision of free health care services at health centres to CHWs and their families as fringe benefit. This is an option requiring relatively small initial investment cost and the decision of implementation is in the domain of LDHMT's authority. The Project needs to review the experiences of similar efforts in other regions and plan practical and effective measures to introduce the option.

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[26] For more information on this issue, please refer to *"Summary of Key Findings and Recommendations: Institution Building and Local Governance related to Development in Zambia Peri-Urban Settlements,"* Lusaka City Council and CARE Zambia, July 2001.

[27] For more information on lessons learnt from experiences in George Compound, please refer to Annex *8.6 Lessons Learnt from community-based GMP+ in George compound.*

5. Project design

Based on the analysis of problems in Chapter 3 and in line with the strategies formulated in Chapter 4 to address the problems, the Project is designed, comprising Overall goal, Project purpose, Outputs, Activities, Inputs, and Important assumptions. To realise Project purpose "improved health status of under-5 children in selected health, four Outputs are selected in the areas of ***capacity building of LDHMT, Community-based growth promotion, environmental health,*** and ***case management and community referral,*** each of which addresses the causes leading to the core problem at different levels. After the completion of the Project and with continuous commitment and efforts of LDHMT in cooperation with the concerned parties, the Overall goal is expected to achieve "improved health status of under-5 children in Lusaka District".

5.1 Overall goal

5.1. Overall goal is the development effect expected as a result of the achievement of Project Purpose. Overall goal of the Project is "**Improved health status of under-5 children in Lusaka District**". Although any particular target age of children was not specified at the initial stage of PCM workshop, the Project was decided to focus on the most vulnerable group of children, i.e. under-5 children. It is also assumed here that after the Project has produced expected outputs and achieved the Project purpose in selected health centre catchments, LDHMT takes an initiative to replicate the activities in other parts of Lusaka District and realise Overall goal.

5.2 Project purpose, Outputs, and Activities

5.2.1 Project purpose

5.2. Project purpose is the goal that is expected to be realised by the completion time of the Project. As the Project selects several health centres catchments for the target areas of intervention, the Project purpose is defined as "**Improved health status of under-5children in selected health centres catchments**". Six health centres's catchments (George, Ng'ombe, Chipata, Mtendere, Chawama, and Kanyama) are tentatively selected as project sites in discussion with LDTMT. This selection may be reviewed and revised as needs arise and in reference to the selection criteria.[28]

5.2.2 Outputs and activities

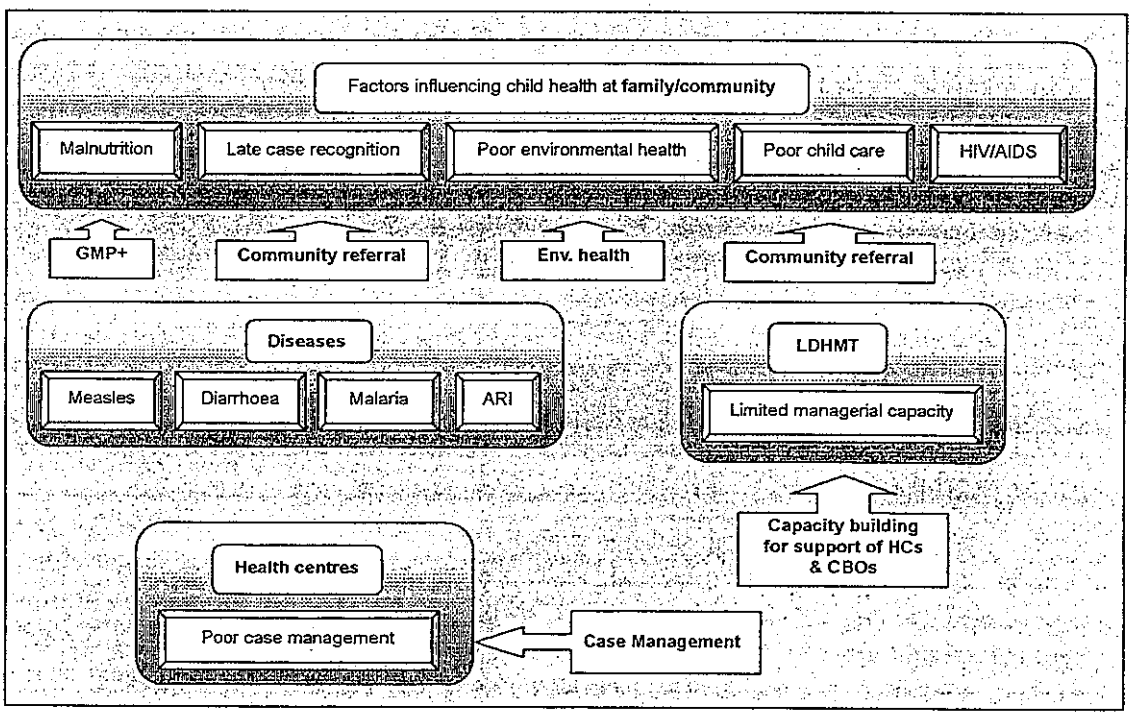
5.3. Outputs are intermediate goals that are expected to to realise the Project purpose and clarifies the measures for its achievement. To address the problems described in Diagram 3.1 and achieve the Project purpose, four outputs are selected in the Project. As Diagram 5.1

[28] The selection criteria discussed with LDHMT are: (1) where public health problems such as cholera, dysentery and other child diarrhoeal diseases are prevalent; (2) where burden of disease is relatively heavier, and/or poverty is prevalent; (3) where there are observed problematic patters of health-seeking behaviour; (4) where institutional capacity building was done by Phase I of the Project; (5) where other donors' projects/activities are still weak in the similar area of interventions; (6) where there is a need/opportunities for enhancing community participation; and/or, (7) other criterion/criteria as agreed upon in the Project's Steering Committee.

indicates, each output addresses the bottlenecks inherent in *family/community, health centres,* and *LDHMT* levels.

5.4. It is worth noting here that no direct output is included to address the issue of HIV/AIDS in the Project, though it is recognised in the problems analysis that it has negative impact on child health in the form of mother to child transmission and prevalence of orphanage due to deaths of caretakers. The Project, however, tackle this issue by integrating measures into the activities of the outputs. Such measures include: awareness raising and facilitating of behavioural change through IEC focusing on HIV/AIDS, door-to-door health education, health talk at GMP+ sites or other places by CHWs, and training of health centre staff. This issue is further discussed in 5.4.3 regarding efforts being made outside the Project.

Diagram 5.1 Relationship between problems and outputs



Output 1 Community-based child growth promotion (CBCGP) is enhanced

1.1 Develop community based child growth promotion(CBCGP) package at the level of the District

1.1.a Develop guidelines on and monitoring & evaluation system for community based child growth promotion

1.1.b Develop and revise training manual for CBCGP

1.1.c Develop Materials for GMP+ (training guide, training manual, counselling cards, tarry form, register book and IEC materials)

1.2 Conduct household survey and register under 2 children

1.3 Analyse demand for CHWs and NPs with stakeholders

1.4 Conduct capacity building

1.4.a Conduct TOT for DHMT and Health Centres staff in CHWs/NPs training

1.4.b Train community members as CHWs and NPs

1.4.c Orient trained CHWs and NPs to an adopted approach of GMP+

1.4.d Conduct refresher workshop for CHWs and NPs
1.4.e Strengthen capacity of NPs in nutrition counseling
1.5 Conduct GMP+ and follow-up activities
1.6 Conduct monitoring and evaluation
1.6.a Train DHMT and health centre staff in monitoring and evaluation
1.6.b Conduct monitoring and evaluation following the guidelines
1.6.c Conduct evaluation meeting at each level of the District, Health Centre and CBOs
1.7 Develop IEC strategies and promote utilization of IEC activities
1.7.a Develop IEC strategies
1.7.b Conduct IEC activities
1.8 Share information and experience on community based child growth promotion activities
1.8.a Hold joint meeting for CHWs and NPs
1.8.b Conduct field tours for CHWs and NPs within and out of Lusaka
1.8.c Initiate coordination meeting with stakeholders & donors

5.5. Phase I of the project observed an increase of participants in community based GMP+ activities. This activity is well sustained through (1) active participation in GMP+ of CHWs with practical knowledge gained through six-week training program, (2) supporting supervision of the health centre and (3) community's recognition on the role played by CHWs. This activity is extended to other areas of selected health centres catchments, aiming to expand the coverage of vaccination, detect malnourished children at early stage, and take follow-up actions.

Output 2 Community-based environmental health services are improved

2.1 Strengthen capacity of George Environmental Health Committee to ensure sustainability
2.2 Develop PHAST guidelines and training manual including visual aids
2.3 Conduct capacity building
2.3.a Conduct TOT for DHMT and HC staff on PHAST approach
2.3.b Hold PHAST workshop and identify priority needs on environmental health in line with child health
2.4 Support CBOs to plan and implement their action plans to address priority needs
2.5 Conduct monitoring and evaluation following the guidelines
2.6 Develop and carry out IEC activities concerning environmental health and personal hygiene in communities
2.7 Support cholera control and prevention programme in the community
2.8 Hold annual workshop for water and sanitation with stakeholders

5.6. Water and sanitation is regarded as priority issues, as they are especially vulnerable to environmental hazards in air, water and soil due to premature immune system and detoxification mechanisms. Contaminated water and exacerbated hygiene condition could lead to high incidence cases of water borne diseases, malaria, and others among under-5 children. IEC component aiming at nurturing preventive and hygiene behaviour among young generation is also incorporated, responding to increasing demand on youth to act as caretakers of smaller children, largely due to the impact of AIDS[29].

5.7. *PHAST* was used as a tool of participatory analysis and planning for improving

[29] There are reports pointing out that impact of the epidemic is being felt as changing family structure and patterns of traditional socialisation.

hygiene and sanitation conditions in George compound. The George experience revealed that the approach helped the residents identify and priority hygiene and sanitation issues and motivated them to form the task group to work for dealing with them. In addition, cost-sharing scheme was built in community activities. The committee formed actively pursued external funding after acquired the skill in project proposal writing. To complement the community efforts, IEC activities are introduced to facilitate behavioural change of people to maximise the impact from improved hygiene and sanitation conditions.

Output 3 Capacity of case identification and community referral for under 5 children is developped

3.1 Conduct IMCI workshop
- 3.1.a Train instructor for IMCI at LDHMT
- 3.1.b Conduct IMCI workshops for LDHMT and Health Center staff
- 3.1.c Train CHWs and NPs in community IMCI

3.2 Develop referral system between HCs and community
- 3.2.a Review and develop "Referral Forms" from community to HCs
- 3.2.b Promote utilisation of "Referral Forms"
- 3.2.c Establish effective feedback system from HCs to CHWs

3.3 Establish community health post for community referral
- 3.3.a Conduct feasibility study on health facilities run by CBOs to serve as community referral points
- 3.3.b Implement Pilot project of these health facilities
- 3.3.c Replicate facilities in other areas

5.8. Late case recognition of diseases at family/community level is identified as one of the leading causes to high morbidity and mortality among under-5 children. CHWs and NPs assume additional responsibility for case identification and referral from community to health centres. To assist them engage in the task, effort will be made to establish facilities to be operated by CBOs as not only community referral point but the source of income generating. Furthermore, the referral between community and health centres is complemented by the use of "Referral Forms", establishment of feed back system, and education to parents.

5.9. This output is also intended to assist health centres in upgrading their capacity in identifying and taking proper care of sick children. Combined with strengthened capacity of case identification and referral at community level, the output is expected to contribute to lowering of case fatality rate of priority diseases among children.

Output 4 Capacity of LDHMT to support Health Centres & Community-Based Organisations (CBOs) is strengthened

4.1 Institutionalise system of support to CBOs
4.2 Assign LDHMT staff to coordination & supervision of community based health activities
4.3 Train LDHMT staff and Health Centres in coordinating CBOs and handling community based activities
4.4 Conduct monitoring for implementation of community activities on Action Plans of District and HCs
4.5 Conduct capacity building for NHC members in leadership and management of community based activities
4.6 Conduct institutional building for CBOs

4.6.a Conduct capacity building for CBOs to ensure sustainability
4.6.b Strengthen financial capacity of CBOs

5.10. The Project aims to assist LDHMT in building the capacity to support health centres and CBOs, which contributes to sustaining of community-based health activities. LDHMT is expected to assign the staff for the Project, which enable him or her to acquire the skill in managing the activities and continue to do so after the completion of the five-year Project. In addition to the assignment of the staff, and with the assistance of the Project, LDHMT is to take an initiative on strengthening its capacity by appraising the current management system and formulate a plan to mitigate bottlenecks in the system and assist health centres and CBOs. Among others, LDHMT specifically aims at devising a mechanism to support and sustain the motivation of CBOs.

5.3 Inputs

5.11. Japanese and Zambian sides contribute in puts to the Project in the following manner.

5.3.1 Inputs from Japanese side

5.3.1.1 Experts

5.12. Project leader, project coordinator, community health, health planning and management, participatory methodologies, IEC, equipment and maintenance, monitoring and evaluation. If necessary, short-term experts in other areas will be dispatched by JICA.

5.3.1.2 Provision of the equipment

5.13. Equipment is to be procured and provided regarding the Project activities.

5.3.1.3 Training in Japan

5.14. Trainees are to be dispatched to the training programs in the fields pertaining to community health, environmental health, and others.

5.3.1.4 Funds for hiring local consultants and Project Personnel

5.15. Funds for hiring local consultants, who will perform specific time-restricted technical tasks, will be allocated within the Project budget (Please refer to Annexes 8.6 for more information).

5.16. In addition, local Projecf Coordinators/Assistants may be hired to assist routine administrative and programmatic undertakings.

5.3.2 Inputs from Zambian side

5.3.2.1Staff allocation

5.17. Counterpart staff, who has overall responsibility of coordination and supervision on the Project's activities, will be assigned in the LDHMT.

5.3.2.2 Buildings, facilities and equipment

5.18. Office cost at LDHMT, expenses for administrative cost, budget for continuation of achievements of the Project are borne by LDHMT.

5.4 Important assumption and risk analysis

5.4.1 Overall goal level

- Political and social stability is maintained

5.4.2 Project purpose level

- Donors' funding should be maintained at acceptable level
- Environmental health/housing conditions in the compounds in Lusaka District are not worsened

5.19. Zambia heavily depends on donor's funding and contribution to its finance for its development budget, approximately 45% in 1997 and has not changed significantly in 2000 (JIFM 2000). Donors' contribution influences Zambia government to sustain their development efforts. Donors have been supporting Zambian health reform. Unless the policy does not change due to the change of the government, for example, it is unlikely that donors reduce the assistance to the health sector, though it should be borne in mind that there used to be a significant discrepancy between commitment and disbursement of donors' funding. In addition, the funding to district level is increasing, which is in line with the government policy and the Memorandum of Understanding signed in November 1999. Crude estimate reveals that province and district received 47% of the total budget in 1998 and 55% in 1999.

Table 5.1 Donors' commitment and disbursement (1995-2000)

Unit: '000 US$

Year	Commitments	Disbursement
1995	46,063	33,163
1996	44,736	42,199
1997	64,463	49,205
1998	53,611	30,322
1999	35,902	41,297
2000	59,698	N/A

Source: JIFM (Volume 2, p. 28, 2000)

5.20. Population growth of Lusaka District reaches 4% whilst the national average ratio is 2.9% (CSO, 2001). Dissolution of mining company and dependence on rain fed agriculture, both of which lead to unstable income in the rural areas may be contributing factors to the growth. Although donors and NGOs are supporting to the MLGH and Lusaka City Council for capacity building in water and sanitation, the trend of population growth and the capacity of MLGH and Lusaka City Council in managing the issue need to be carefully monitored to check the conditions of environmental health.

5.4.3 Output level

- Purchasing power of household income does not decrease significantly

5.21. Purchasing power of household income needs to be carefully and regularly monitored by the trend of market commodity price and statistical data. Recent price hike of mealie, from ZK25,000 to ZK45,000 per 25 kilogram, hard hit the vulnerable group. As there does not seem to be cheaper alternative staple food, this price hike is likely to reduce household expenditure on health and other non-food items. Though the government has started to import maize from overseas, which is expected to change upward trend of the price, the trend of mealie meal price needs to be continuously monitored.

5.4.4 Activity level

- Assurance of stable supply of essential drugs, equipment, consumables, vaccines and micronutrients is secured at Health Centres
- Adequate number of staff at DHMT and Health Centre levels is secured
- CBoH disburses CHIF fund in timely manner

5.22. The Project is aimed to build the capacity of LDHMT to assist health centres and CBOs for their activities. Though procurement and supply of drugs, equipment, and consumables such as spray for cholera control is critical as LDHMT's function to support health centres, there is occasional shortage of supply. As Output 4 partly, if not comprehensively, addresses the issue, the situation of procurement and supply to health centres needs to be regularly monitored.

5.23. As mentioned in 3.1.1, the number of staff does not meet the standard, particularly at health centres. The total number of health centre staff is 1,444 in Lusaka District, which are 333 less than staffing requirement. Although LDHMT has a difficulty in increasing the number of staff under the present financial constraint, it can make an effort to upgrade the skill of the staff by, for example, IMCI training, though change of the staff number would have significant impact on the health service provision.

5.24. Community Health Innovation Fund (CHIF) is managed by CBoH and targets innovative health activities. Most of the fund are disbursed to water and sanitation related infrastructure. Although the data is not available regarding the timing of disbursement, LDHMT needs to watch the timing of disbursement and take a necessary action if disbursement of CHIF funding is delayed.

6. Project justification

The Project is justified in terms of ***relevance***, ***effectiveness***, ***efficiency***, ***expected results***, and ***sustainability***. The Project has much relevance as it reflects the priority needs specified through the participatory planning process and health policy documents. The Project is effective as it targets the most vulnerable group: under-5 children. Efficiency of the Project is ensured by targeting the group of approximately 180,000 population, which goes beyond reduced morbidity and mortality to increased productivity and income. The Project is intended to achieve the results of (1) incorporating the lessons from the Project into national health policy and (2) establishing mechanism and capacity of relevant institutions at district level. All of these results lead to sustainable provision of health services.

6.1 Relevance

6.1.1 Public benefits and equitability

6.1. The Project is well justified as investments into the public sector by the following three traits. One such trait is that it aims at strengthening of social service/welfare sector in a context of premature market economy with limited spending power of constituencies[30]. To date, public health institutions remain the principal health services provider in Zambia, after having gone through almost a decade-long deliberate transformation into market-oriented economy. At the same time, ***the Project focuses on preventative and promotional component***, which is less likely to be covered by the private sector. It shall be safe to assume that the situation would continue to be so in the case of preventive and promotional services provision, as well as services for under-5 children[31]. Hence, it essentially is of matters in the public domain.

6.2. Secondly, the Project is about a quest of the public administration on ***how best the civil minimum can be guaranteed to the vulnerable population***: in this case, as described in Chapter 2.2 and 2.5.3, residents in urban poverty-stricken areas. Its very intention of targeting vulnerable and disadvantaged areas derives from idea of fairness and equity.

6.3. Thirdly as pointed out in 4.2.1 and 4.2.3 the Project connotes a potential of expanding the package to other peri-urban area in and outside of Lusaka District, avoiding unfairness between the initial Project sites and other areas with similar conditions.

6.1.2 Responsiveness to local priorities and needs

6.4. Formulation process of the Project was guided and informed by the followings:

1. Health Sector Reform and the National Health Strategic Plan (See 2.6.2);
2. 2002 Action Plan of LDHMB
3. Lessons learnt from the former PHC Project as well as other relevant projects;
4. A rapid needs assessment survey in selected Health Centre catchments; and,
5. Objective-oriented planning process with participation of various stakeholders in

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[30] For more information on the topic of poverty and social development, please refer to Chapter 7 of the *"Report by the Research Group on Development Assistance to Southern African Region: Part 4 Zambia Main Report," December, 2000, JICA.*

[31] GRZ maintains free service policy for services relating to child health, which assumingly motivates users to use public health facilities.

Lusaka District (See Chapter 5).

6.5. Among them, an "objective-oriented planning process," facilitated by the PCM method, enabled analysis of underlying causes of the manifested problem, *i.e.* high incidence of under 5 children's morbidity and mortality in urban unplanned settlements. The subsequent objective analysis could then concentrate on redressing issues identified, followed by the alternative analysis which resulted in selection of feasible and most effective options. The result of the workshop were also supported by desk reviews and a follow-up rapid study in the model sites. The strategy/design of the Project was formulated in order to respond to the local needs and priorities identified in the above-mentioned processes.

6.1.3 Relation with Japan's aid policy

6.6. The Government of Japan has been assisting Zambia for its development with special emphasis on six priority areas: (1) promotion of private economic activity, (2) improvement of access to quality health care services, (3) improvement of access to quality primary/secondary education and technical/vocational training, (4) steady expansion of agricultural production through assisting small scale agriculture, (5) improvement of access to safe water, and (6) environmental conservation.[32]

6.7. Regarding improved access to health care services and safe water, Japan is extending its assistance to the primary health care services, aiming at reducing infant and maternal mortality in Zambia through a combination of various assistance schemes. Thus the Project complies with the priorities set by Japanese aid policy with Zambia.

6.2 Effectiveness

6.2.1 Logicality of the plan

6.8. As Diagram 3.1 shows, problems are observed at family/community, health centres, and LDHMT, all of which are leading to high morbidity and mortality among under-5 children. Activities of the Project's outputs address problems at each level except the issue of HIV/AIDS, which is assumed to be dealt with by other interventions. The Project incorporates the capacity building of LDHMT, which is aimed to ensure that the activities of the Project surely lead to the achievement of outputs and Project Purpose and sustain the positive impacts.

6.2.2 Proper level setting of the Project Purpose

6.9. Project Purpose adequately addresses the core problem and leading causes of under-5 children's morbidity and mortality, whose seriousness is affirmed by the LDHMB's Action Plan 2002. Indeed, the objectively verifiable indicators are determined to reflect the goal of the Action Plan.

6.2.3 Important assumptions

6.10. Important assumptions are selected and analysed in 5.4, though there still remains uncertainty and lack of information in some assumptions. Such assumptions are to be carefully

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[32] JICA (2000), *Study for Japan's official development assistance to Southern Africa, Volume 4, Zambia Main Report*, p. 123

monitored during the Project period. The Project needs to be revised if important assumptions become unlikely to be met.

6.3 Efficiency

6.3.1 Cost vis-à-vis outputs/benefits

6.11. With the inputs indicated in 5.3, the Project attempts to prevent diseases or control sources of infections for 87,919 children under 5 years of the age in selected health centre catchments (i.e. 20% of the total population (439,596) of tentatively selected catchments of six health centres). The number of beneficiary would become larger as the Project has a component of water and sanitation and its positive impact extends to adults and children older than five years of age. The Project also recognises itself as being an integral part of, and as a contributor to, a larger framework of public health interventions, such as roll-back malaria, tuberculosis control, HIV/AIDS programme, etc.

6.3.2 Cost vis-à-vis impact

6.12. Possible impacts include (1) reduced morbidity and mortality, (2) increased lifetime income and/or productivity of those who have recovered, and (3) reduced medical expenditure which otherwise would have been spent, though it is not possible to come up to EIRR or FIRR as these expected results cannot be quantified in currency terms. Furthermore, the components of primary health care, especially preventive measures are cost efficient compared with curative measures.[33]

6.4 Expected results

6.4.1 Implications for the health policies

6.13. In addition to the outputs and purpose stipulated in the Project Design Matrix and its expected impacts, the Project will seek ways to contribute to the further improvement of health policies. Initiatives under the Project are in many ways about finding answers to long-asked questions in the field of primary health care: what does it look like and how can it be achieved to have an effective and sustainable community-based services provision in peri-urban setting? Such initiatives include introducing community-based environmental health related services with good cost recovery, self-reliant community-based growth monitoring services, defining roles and functions of district health management team to best render supports to aforementioned activities, and, introducing and establishing cost effective health referral points/posts in peri-urban areas.

6.14. Lessons learnt from the Project undertakings will be shared in appropriate policy-related forums for discussion. When such lessons are found useful and thus incorporated into policies and guidelines, it will open up possibilities for other locations with similar predicaments to benefit from the experiences, thereby maximising impacts of the initial inputs

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[33] See Economic Institute of World Bank (1991), *Economics for Health Sector Analysis* for cost comparison of health care services. Per capita cost of curative service costs $7 (in case of Turkey), EPI $0.05 (Indonesia), water and sanitation $2.70 (Sub Sahara Africa), and supply of nutrition supplement $1.75 (India)

under technical cooperation scheme.

6.4.2 Contribution to institution building

6.15. Ultimate purpose of the technical cooperation Project is to establish framework and capacity of local institutions so that they can continue generating positive outputs even beyond the cycle of the Project. To this end, the Project will promote institutionalisation of mechanisms/systems, which can generate good practices and much needed outputs. One such mechanism is ways to generate consistent resources through community participation in order to support and sustain health interventions at the community level. Another is to create a conducive environment in which each actor, be it LDHMT, Health Centres, NHCs, RDCs and/or CBOs, can be brought on board and play its role to produce synergic effects.

6.4.3 Ripple effects on Socio-economic conditions

6.16. Decreased burden of disease on population can contribute to higher lifetime income and high productivity, provided that there are ample opportunities for income generation. In other words, investing into health sector can have positive external (economic) effects to productive sectors in that it contributes to maximising healthy workforces in the future as well as precluding external diseconomy.

6.4.4 Potential negative impact

6.17. The Project does not expect negative impact at this stage. However, if the Project is not careful enough in coordination with other external support agencies, there is a potential threat of losing solidarity of a community (Please refer to 4.3.1 for more explanation). At the same time, new interventions should be carefully and pragmatically designed to avoid discontinuous and erratic patterns of services provision, in order to secure community's credibility and trust in health service providers (Please refer to 4.3.2 for more explanation).

6.5 Sustainability

6.18. As already mentioned in 3.2.5, weak linkage with health centres is recognised as a weakness. This is reflected in Output 4 "capacity building of LDHMT", which is intended to strengthen LDHMT to support health centres and CBOs to sustain their community based health activities. Thus, though the Project primarily focuses on selected health centres catchments, the component and mechanism to sustain the activities after the completion of the Project are embedded in the Project.

6.19. As for financial resource to continue to implement the activities or expand them to other peri-urban areas, the percentage of the budget allocation to local authorities have been increasing in line with the government decentralisation policy and district basket funding, which is explained in 5.4.1. Furthermore, measures to generate income to sustain community based health activities by CBOs will be studied and experimented in the Project. Although the result is yet to be seen, securing of sustainable primary health care activities is an underpinning strategy of the Project.

7. Monitoring and evaluation

Monitoring and evaluation activities are integral parts of the Project activities, and will be utilised to improve the design of the Project. Monitoring activities under the Project include two components: progress monitoring and performance monitoring. Internal evaluation will be conducted twice: in the middle and at the end of the project cycle, using the PDM. Result of the monitoring and evaluation activities is expected to be shared with relevant stakeholders.

7.1 Integrating Monitoring and Evaluation into Project Design

7.1. Monitoring and evaluation activities should not be an end on its own, but rather the means throughout the Project phase to effectively maintain the Project's relevance to the National and District policies/strategies as well as to the issues that the Project intends to address. As such, the following monitoring components need to be integrated into Project design.

i) data collection and management;

ii) institutional arrangements for managing information; and

iii) use of feedback from monitoring and evaluation to fine-tune Project contents.

7.2. In line with the regulation of Project-Type Technical Cooperation Scheme of JICA, the Project will be evaluated twice – during and at the end of the project cycle. It assesses, as systematic and objective as possible, its design, implementation and results in light of the five evaluation criteria: the relevance, effectiveness, efficiency, impact and sustainability of outputs/outcomes obtained by project interventions. Again, the result/lessons emanating from the evaluation should be utilised to propose revisions to the plan of a particular project, and further be reflected into planning, implementation and evaluation of other similar project.

7.2 Monitoring Procedure

7.2.1 Progress Monitoring

7.3. Progress Monitoring refers to ongoing check-ups by the Project Management on whether the activities stipulated under the Plan of Operations (PO) are executed/implemented on schedule. The Plan of Operations can be a good tool to administer monitoring procedures at this level. 'Implementers', as stipulated in the PO, can report the progress they made to 'Person in Charge'. The Person in Charge of these activities can raise issues, as they arise, to the Project steering committee, or LDHMT management meeting if it requires urgent attention.

7.2.2 Performance Monitoring

7.4. Performance Monitoring refers to occasional measuring of performance attained through implementation of the Project. Measurement shall be done against targets as stipulated in the PDM as objectively verifiable indicators. Benchmarks or base-line data should be obtained by the Project either from an independent survey or existing secondary information.

7.5. It is expected that the Project Management share the result of performance monitoring with broader audience through aforementioned forums.

7.3 Evaluation Procedure

7.6. Mid-term evaluation will be conducted in the middle of the 5-year Project Cycle. In light of OUTPUT indicators and PROJECT PURPOSE indicators, as appropriate. Based on the result of the Mid-term evaluation, project strategy(ies), directions and components are reviewed and discussed for change. Again, the result of the mid-term evaluation be shared with broader audience for the purpose of obtaining technical and policy-level advises.

7.7. At the End of the Project Cycle, Project will go through evaluation applying the Project Cycle Management (PCM) method[34]. External impact evaluation may be considered additionally, in order to draw lessons learnt from the Project experiences, if considered useful.

[34] Please refer to FASID publication on PCM – Monitoring and Evaluation for more details.

8. Annexes

8.1 PDM

As attached.

8.2 Plan of Operations

As attached.

8.3 TOR for the Long Term Japanese Experts

8.3.1 Chief Advisor

Liaison: Director District Health

Tasks:

(1) To gather and maintain information concerning wider policy framework under the ongoing health sector reform through reviewing documentations produced by the CBoH, Ministry of Health and SWAps-related groups, and attending relevant meetings both at national and district levels;

(2) To explore ways in which the Project can be best contributing to wider arena in the health sector;

(3) To explore ways in which the Project can share information, establish cooperation and/or collaborative relationships, with and among other stakeholders, e.g. relevant governmental, non-governmental, and international organisations;

(4) To advise on directions of the Project based on the above undertakings;

(5) To direct and supervise Project staff (Japanese and local) in order for different components of the Project to produce maximum synergic effects; and,

(6) To direct and supervise Project staff (Japanese and local) to produce the Project's action plan and annual report.

Qualification: Adjustability to socio cultural environment of Zambia

8.3.2 Project Coordinator

Liaison: Manager, Administration

Tasks:

(1) To manage administrative matters including finance, accounting, personnel (local staff), correspondence with JICA headquarters and resident office, procurement and contracting;

(2) To manage and facilitate public relations;

(3) To assist the Chief Advisor with the task specified in (2) and (3); and,

(4) To monitor progress of implementation schedule as stipulated in the Plan of Operations.

Qualification: Adjustability to socio cultural environment of Zambia

8.3.3 Expert in Community Health

Liaison: Professional staff through LDHMT's Project liaison officer

Tasks

(1) To gather and maintain information concerning policy framework(s) under the relevant sub-sector(s) through reviewing documentations produced by the CBoH, Ministry of Health, Ministry of Local Governmental and Housing, and SWAps-related groups, and attending relevant technical meetings both at national and district levels;

(2) To explore and advise the LDHMT on ways in which community-based organisations can initiate, implement an sustain health-related activities;

(3) To provide technical backstopping on various training activities in the area of IMCI (case management of service providers and community-based case identification and referral), GMP+, and PHAST approach;

(4) To explore ways in which the Project can be best contributing to wider arena in relevant technical sub-sector(s) such as child health, nutrition, water and sanitation and community participation; and,

(5) To facilitate sharing of information, establishing cooperative and/or collaborative relationships with and among other stakeholders, e.g. relevant governmental, non-governmental, and international organisations.

Qualification: Public health, adjustability to socio cultural environment of Zambia

8.3.4 Expert in Health Planning & Management

Liaison: Manager, Planning & Development

Tasks:

(1) To assist the Chief Technical Advisor in gathering and maintaining information concerning wider policy framework under the ongoing health sector reform through reviewing documentations produced by the CBoH, Ministry of Health and SWAps-related groups, and attending relevant meetings both at national and district levels;

(2) To provide technical advises to LDHMT on ways in which the Project can be best contributing to wider arena in the health sector reform as well as the district-level health administration;

(3) To provide technical backstopping to the review, planning and implementation of the enhancement of the LDHMT's management system to support community-based health interventions;

(4) To provide technical backstopping to LDHMT on the process of introducing community-based facilities as referral points; and,

(5) To advise and facilitate management trainings of LDHMT staff.

Qualification: Knowledge on health economics is preferred. Adjustability to socio cultural environment of Zambia

8.4 TOR for the Short Term Japanese Experts

8.4.1 Expert in Monitoring and Evaluation

Tasks:

(1) To train and advise relevant LDHMT staff in data gathering and monitoring methodologies;

(2) To design tools by which the health centres can easily record and analyse health information, in reference to the "*Health Management Information System: Indicators*," published and updated by the Directorate of Monitoring and Evaluation, Central Board of Health;

(3) To train relevant health centre cadres in the application of the above tools; and,

(4) To provide technical backstopping to ensure the data of Objectively Verifiable Indicators are regularly collected and compiled for monitoring and evaluation of the Project.

8.4.2 Expert on Participatory Methodologies

Tasks:

(1) To provide technical advise and assistance to cadres who obtained ToT training in PHAST under Phase I of the Project, for appropriate follow-up actions;

(2) To provide ToT training in participatory methods such as PHAST to additional cadres, if considered necessary; and,

(3) To provide technical backstopping to operations of LDHMT and Health Centre staff on community-based participatory process, institutional building, and other relevant issues concerning community participation.

8.4.3 Expert on IEC

Tasks:

(1) To provide technical backstopping to relevant IEC cadres to design behaviour change communication interventions on child health, hygiene education, and case identification for the community; and,

(2) To provide technical backstopping to relevant IEC cadres to design behaviour change communication interventions on health and hygiene practices for the schools.

8.4.4 Expert on equipment of maintenance

Tasks:

(1) To provide technical backstopping to relevant LDHMT/Health Centre cadres to design cost-effective operation, maintenance and management plan; and,

(2) To train relevant Health Centre cadres on in-house operation, maintenance and management issues.

8.4.5 Expert on other areas

There may be needs on short-term experts in other areas, which need to be considered as and when required.

8.5 TOR for the Counterpart Personnel

8.5.1 Liaison Officer (in Community Health)

It is suggested that the LDHMT designate one person as a liaison officer for the Project, who will work together with the Japanese experts to oversee progress of the Project. The person is expected to have a background on Community Health as well as certain managerial experiences.

8.5.2 Locally Hired Project Staff

Two Project Coordinators/Assistants can be hired under the Project to assist day-to-day administrative and programmatic undertakings under the Project, if considered necessary.

8.6 Local Consultants

The Project will promote use of local consultants to be complementing Japanese Experts in providing technical supports to the Project. Some of the areas identified for support by local consultants include:

8.6.1 Baseline Survey

Based on the agreed Objectively Verifiable Indicators in the Project Design Matrix, the Project is required to gather baseline data, which will be used as monitoring and evaluation purposes.

8.6.2 Feasibility Study on community-based health facilities

The study needs to be carried out in order to determine feasibility, scope and contents of the planned community-based facilities. The result of the Study will be presented to CBoH and MoH as a basis for management decision to be taken on this issue.

8.6.3 Capacity building in HMIS

Importance of reliable data to inform directions of health interventions cannot be

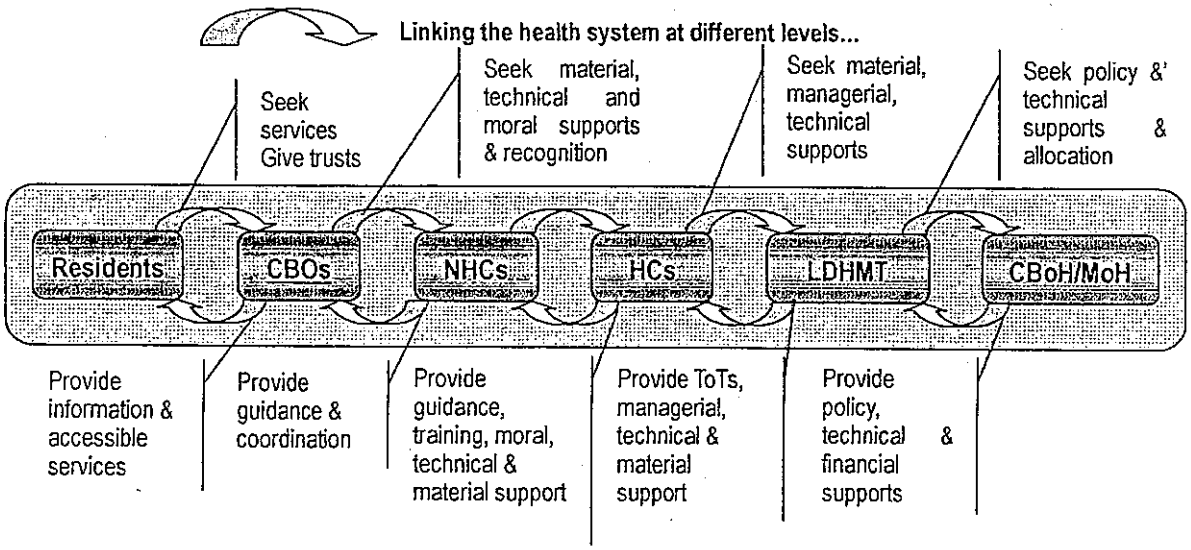
overemphasised. In this regard, the Project will require an effective model of capacity building at the health centre level, for further application by the LDHMT. In so doing, the consultant can design a model of capacity building in line with the "*Health Management Information System: Indicators,*" published and updated by the Directorate of Monitoring and Evaluation, CBoH.

8.7 Lessons Learnt from community-based capacity building in George compound

In this section, lessons drawn for general strategic matters are summarised. More concrete lessons are attached in the next page, together with corresponding points for consideration under Phase II of the Project.

Through interventions under Phase I of the Project, capacity was built among CBOs (especially in CHWs) to effectively carry out community-based GMP+ activities, owing much to a comprehensive module with practical components, enhanced by periodic refresher/skill up courses.

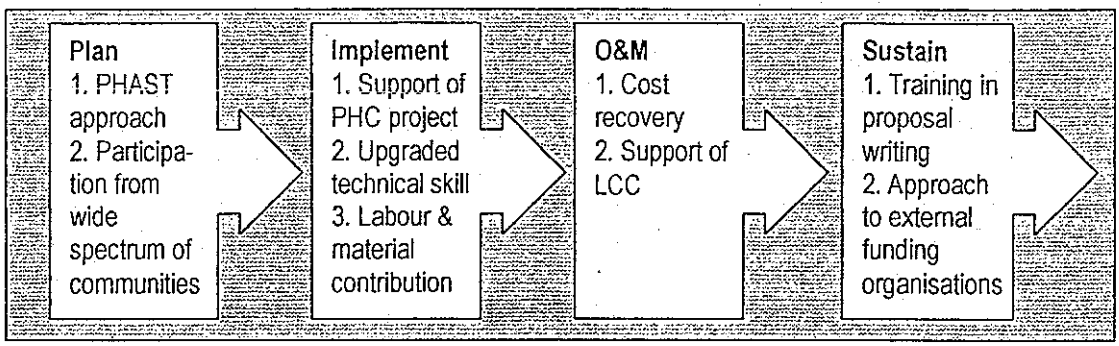
Residents seem to come to trust and rely on CHWs as community resource persons on health matters, which ***increased expectations/demands for services to be provided by CHWs.*** Good channel of communication between the HC staff and CBOs exist, though leaving some rooms for improvement. What kept community-based growth monitoring plus activities going owed much to exceptional dedication and commitment from HC staff and CHWs, and growing felt demands for community-based services. However, such ***motivation remains too fragile and delicate to sustain*** with the current conditions surrounding the CHWs, entailing ***enhanced systematic support*** to CHWs in order for them to live up to the expectation of community members. Nevertheless, supportive links between the LDHMT and HCs and CBoH/MoH was found rather weak – risk factor to the sustainability.



Recognition and moral support from the health system play a major role as CHWs' incentives. The opinion that such recognition be substantiated with monetary and in-kind incentives exists among CHWs, perhaps due to the point-incentive system introduced during Phase I of the Project. There is a need for the health management to come up with and support sustainable and effective ways to generate incentives for the CBOs, either monetary, in-kind or in-tangible forms.

In the area of *environmental health*, Phase I of the Project achieved significant outputs, whose

process can be used to similar activities in Phase II.



In *planning* stage, ***PHAST approach*** was used to facilitate community members' participation in identifying problems in environmental health, planning activities for solution, selecting options, monitoring and evaluating. It also led to the establishment of George Environmental Health Committee (GEHC), which identified priority issues and started actions.

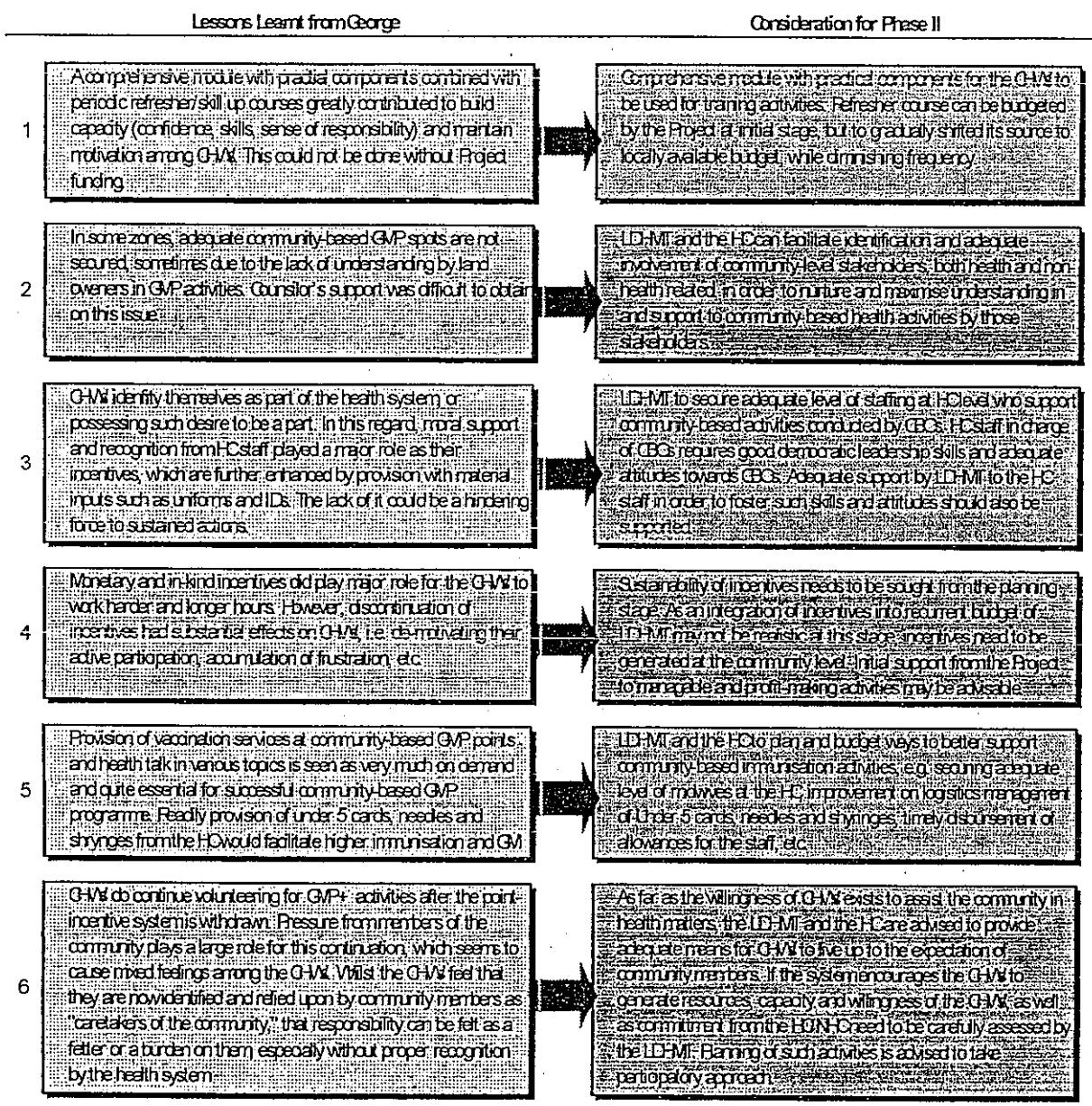
Phase I project also succeeded in securing ***participation of committee members from wide spectrum of the community***. Koshu Fee Paying Toilet Committee have members from the Lilanda market where the toilets are constructed, church, school, the private sector, LCC, and NHC. Members of GEHC are from CHWs, church, George water committee, NHC, NP, etc.

The Phase I project did not only support facilitation of PHAST approach but continued to support the ***implementation*** of the initiatives of the community by ***financial and technical assistance***. Financial support was granted to construction of drainage, VIP toilets and other infrastructure. Community members attended technical training program such as bricklaying. The combination of these assistances functioned well. For example, community members trained in bricklaying could have confidence in their skill and have willingness to work in other similar projects. In addition, community residents ***contributed labour and in kind*** to the construction of facilities.

Regarding ***operation and maintenance***, the schemes implemented under Phase I of the Project incorporated ***cost recovery*** component with the purpose of maintaining the operation of the facilities. User charge for Koshu toilet and shower is decided at ZK300 and ZK700 respectively. Schemes of drainage, garbage collection, and VIP latrines have fee collection mechanism as well. It is also worth noting that the schemes maintain ***good partnership with Lusaka City Council***. Koshu committee, for example, is granted 30% discount of water and sewerage cost.

Efforts were made to ***sustain and expand*** community based environmental health activities. Phase I Project supported the ***workshop of project proposal writing*** to enable committee members to ***approach to external funding agency*** after the completion of the Project. In fact, GEHC was successfully awarded the grant for the construction of drainage by CARE. Furthermore and as mentioned earlier, the environmental health activities normally have ***fee collection mechanism***, which can guarantee sustainable operation if they are properly managed. Koshu Committee has already achieved financial sustainability as it is fully paying salary to the staff from the fee collected after Phase I Project stopped financial grant.

* Distilling Lessons Learnt from experiences in George compound *



Sources: The above information is a result from and analysis of key informant interviews from staffs of George Health Centre (GHC) as well as Group Interviews with three groups of CHWs who work in the GHC catchment area.

8.8 Matters to be considered: suggested health facilities in a community

Phase II of the Project accommodates a pilot component: to establish an urban version of "health posts," or "health facilities," which serve as community referral points. Daily management of these facilities are supposed to be handled by CHWs and other community cadres, as appropriate.

This idea serves for two purposes: One is to address incentive issues; and the other, to effectively respond to swelling demands at the community level.

However, as pointed out in 4.3.2, introduction of new provisions for incentives require careful examination and planning. Therefore, some points for discussion are listed below to guide a decision making process on the issue.

In examining the following discussion points, the four principles of the Zambian Health Sector Reform may guide decisions to be made:

Leadership... New roles and terms of cooperation, required for concerned actors to implement the new initiatives, need to be clarified and checked with its feasibility. Capacity building of the health providers should cover various levels of operation, in order for all the actors to exercise their leadership.

Accountability... The new measures should justifiably result in improvement in quality and equality of service delivery by the health system.

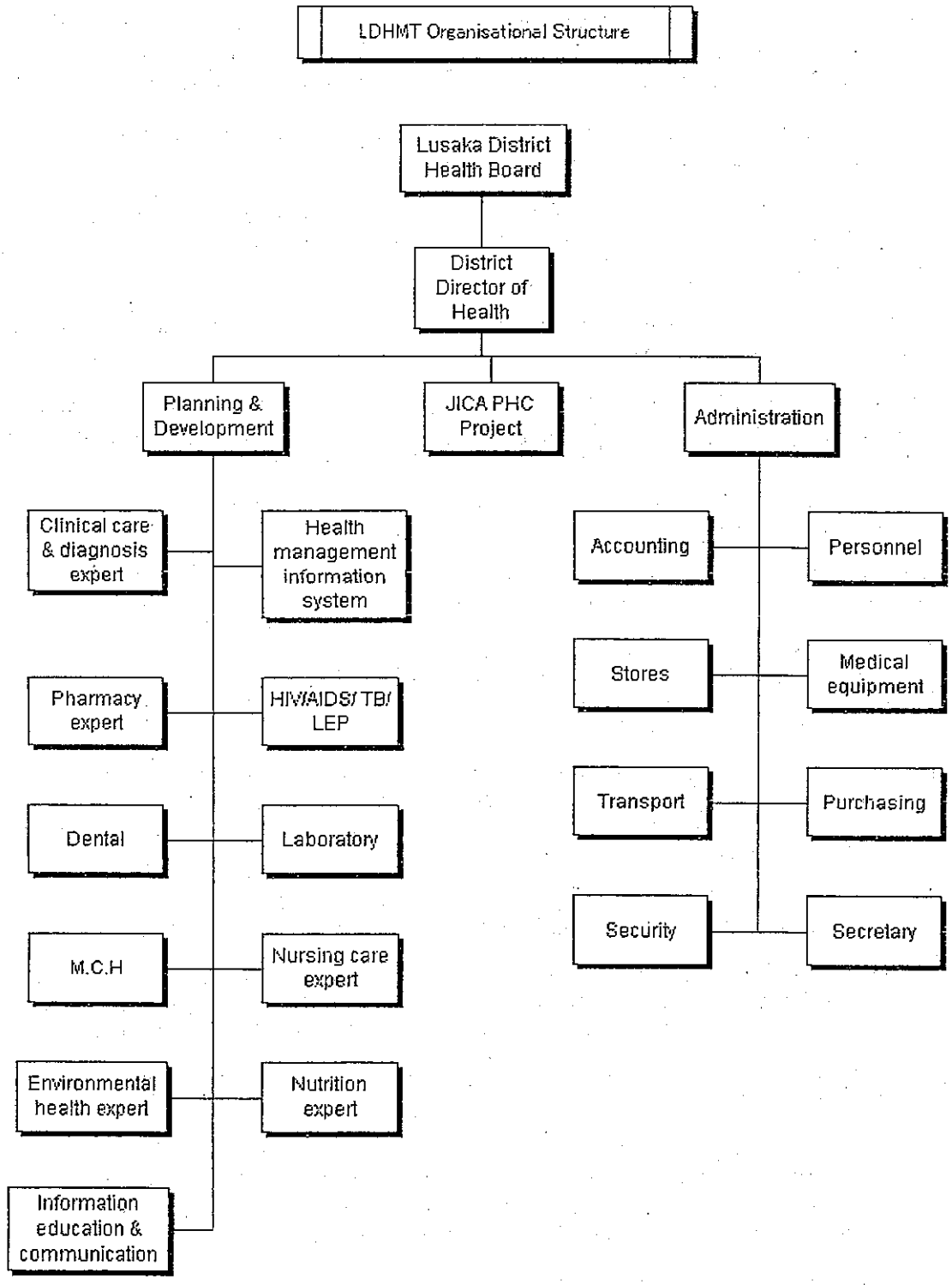
Affordability... Decisions to be based on short-/long-term cost-estimates and affordability by the Health Management, in order to secure continuity of new provisions.

Partnership... No interventions exist in a vacuum. Relevant partnership with various actors as found in different communities be considered when designing new interventions.

Discussion Points ~ Key questions to be asked...

- Defining a package of services ~ *What types of services are most appropriate for the community-based Health Facilities? Should and can the CHWs handle basic curative services like those in rural areas? Should and can the standard Drug Kits be distributed to CHWs? Would the National Guidelines allow distribution of the Drug Kits for urban settings?*
- Setting a physical/material standard ~ *What should the Health Facilities look like? Should it be an extension of CHWs' private home? Should it be more like a sub-clinic?*
- Determining criteria on site designation ~ *How many people should the Facility deal with? How far should the Facilities be from HCs? Should they be located per Ward? What if the areas where road to the HC becomes impassable? Who has and where is strong demands for the packaged services?*
- Ownership of the land and property of the Health Facilities ~ *Should the land/property be owned by CBOs, LCC, or DHMB?*
- Determining social marketing activities ~ *Should they sell drugs? Which Drugs? Is Drug Revolving Fund (DRF) feasible? Who should provide funding and technical assistance to DRF venture? Should they obtain License to sell drugs? Should they only sell ITNs, ORSs, Chlorines and other non-pharmaceuticals? Do they require Business License as retailers?*
- Selecting community cadres to manage and run the Facilities ~ *Which community cadres should be entitled to manage and run the Facilities, CHWs, NPs, TBAs, CHPs, and/or others?*
- Defining status of the Facilities ~ *Are the Health Facilities to become formal extensions within the structure of public services? Or, are they just voluntary initiatives among CBOs, but which can receive material/technical support from the formal system?*

8.9 LDHMT organisational structure



8.10 List of health centres in Lusaka district

Zone	Health Centre	Cathment area population	Type	Number of staff				Outpatient	Inpatient	Dental clinic	Laboratory	MCH	Delivery	Youth health	X-ray
				Doctor	C.O.	RN/RM	ZEN/M								
1	Chelstone	67,183	1st Referral	2	4	12	43	x	x	x	x	x	x	x	
	Chainda	30,538	Small HC	0	3	3	13	x				x		x	
	International Airport	3,500	Small HC	1	0	2	9	x							
	Kaunda Square	29,434	Small HC	0	2	3	17	x				x		x	
	Ngo'mbe	14,975	Small HC	0	2	4	12	x				x		x	
2	Chipata	84,438	Large HC	2	4	12	40	x	x	x	x	x	x	x	
	Mandevu	78,459	Small HC	0	2	4	12	x				x		x	
3	George	99,248	Medium HC	1	7	3	28	x		x	x	x	x	x	
	Matero Reference	61,076	1st Referral	2	8	9	48	x	x	x	x	x	x	x	x
	Matero Main	67,183	Small HC	0	2	1	12	x			x	x		x	
4	Makeni	21,413	Small HC	0	2	1	7	x				x		x	
	Kanyama	114,398	1st Referral	2	8	9	48	x	x	x	x	x	x	x	
5	Chawama	68,515	Large HC	2	9	7	3	x	x	x	x	x	x	x	
	Liyayi	17,827	Small HC	0	1	3	12	x				x		x	
6	Kamwala	54,968	Large HC	3	9	3	25	x	x	x	x	x		x	
	Railway	45,162	Small HC	0	3	5	12	x				x		x	
	Civic centre	22,987	Small HC	0	2	2	12	x				x		x	
7	Chilenje	79,650	1st Referral	2	9	18	43	x	x	x	x	x	x	x	
	Kabwata	62,549	Small HC	2	7	5	14	x				x		x	
	Bauleni	52,356	Small HC	0	4	3	11	x				x		x	
	State Lodge	3,584	Small HC	0	2	2	5	x				x		x	
	Prisons	3,078	Small HC	0	1	1	7	x				x			
8	Kalingalinga	46,570	Large HC	1	7	6	26	x	x		x	x	x	x	
	Mtendere	58,022	Medium HC	0	4	8	23	x			x	x	x	x	
LDHMT	Command Post		Small HC	0	0	0	16								
Total		1,187,113		20	102	126	498	24	8	8	11	23	9	22	1

Note: C.O.: Clinical Officer, RN: Registered Nurse, RM: Registered Midwife, ZEN: Zambia Enrolled Nurse, ZEM: Zambia Enrolled Midwife