Evaluation Grid

1. Relevance

<table>
<tr><th>Evaluation Item</th><th>Survey Item</th><th>Means of verification</th><th>Result</th></tr>
<tr><td>1. Relevance of needs of the target region/area</td><td>-Living condition of the compounds in Lusaka District</td><td>-Statistics
-Interview with C/P
-Interview with MoH & CBoH</td><td>The living condition of the unplanned settlement area in Lusaka district is not good and even worsening.
Lusaka District has surface area of 360 km^2 with the population of 1,558,616 and the population density of 4,329/km^2, which is the most densely populated area in the country. The District has been experiencing a constant population growth.

Though 90% of residents in Lusaka Province have access to piped water, cholera outbreaks in the compounds of Lusaka District in 2003-2004 was resulted from a lack of access to safe water.

The ratio of access to adequate toilet facilities is low. Many residents in compounds use pit latrines. Ventilated Improved Pit (VIP) latrines are also used in the areas, though the number is small. Regular garbage collection is low, 5.9% in the Province. The combination of these environmental situations is negatively influencing the health condition of the residents. The Project selected the catchment areas of six health centres as the target area as these areas are characterized by worse environmental condition.</td></tr>
<tr><td>2. Relevance of needs of target group</td><td></td><td>-</td><td>The Project selected under 5 children as the target group as they are the most vulnerable group in poverty stricken compounds with worsening environmental condition in Lusaka District. According to the data from HMIS of LDHMT, incidence of malaria, respiratory infection (non-pneumonia) and diarrhea are increasing. The incidence of these illnesses of under 5 children is significantly larger than that of 5 and over population.

Table: Four major causes of visitation to health facilities (2002) in Lusaka province
(Unit: incidence rate per 1000 population)
<table>
<tr><th>Disease</th><th>Under-5</th><th>5 and over</th><th>Total</th></tr>
<tr><td>Malaria</td><td>871.5</td><td>169.9</td><td>310.2</td></tr>
<tr><td>Respiratory infection (non pneumonia)</td><td>538.4</td><td>81.7</td><td>173.1</td></tr>
<tr><td>Diarrhea (non bloody)</td><td>474.5</td><td>62.8</td><td>145.2</td></tr>
<tr><td>Respiratory infection (pneumonia)</td><td>187.2</td><td>26.2</td><td>58.4</td></tr>
</table>
Under-5 mortality is 168 per 1,000 births, which is significantly higher than infant mortality and child mortality.</td></tr>
</table>

3. Relevance to the policy of the region	-	-Project report -Interview with MoH & CBoH -Interview with experts & C/P -Interview with donors	The vision of the health reform in Zambia is to provide Zambians with equity of access to cost effective, quality health care as close to the family as possible. The National Health Strategic Plan 2002-2005 identifies the public health priority areas as follows: (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. The Project address the issues of (4) child health, (6) public surveillance and epidemic control, and (7) promotion of safe water, hygiene, and sanitation. Lusaka District Health Strategic Plan 2004-2006 sets the following goals. (1) Reduce he burden of burden of illness from common diseases in the district; (2) Reduce the incidence of adverse reproductive health outcomes; and (3) Improve outputs of the health management systems and governance structures of the district's health care delivery system. The Project is intended to tackle the issues of the first and third goal. GMP+ and PHAST are included as a strategy to address the objectives of reducing morbidity and morality of under-5 children and those of all ages respectively. The Project also focuses on the strengthening of planning and financial capacity of LDHMT and health centres, which is closely related to the third goal.
4. Appropriateness of methodology	-Appropriateness of Project as strategy to address the development issues in the region (approach, target area, synergy effect with other interventions)	-Project document -Project report -Interview with C/P & experts -Interview with donors	The Government of Zambia is promoting the Basic Health Care Package, which is emphasizing community activity, as 80% of illness can be handled at community level. The target area of the Project is the poverty-stricken peri-urban area of Lusaka District with worsening environmental health condition due to high population density and inadequate infrastructure and services. To address two issues, the Project is intended to contribute to the promotion of the community health activities and the improvement of environmental health, both of which lead to the improvement in under 5 children as the target group and the whole population as well. The Project aims to establish an efficient and effective community health system through the implementation of GMP+, environmental health activities and community referral. This Project is also characterized with an emphasis on sustainable community health activities. It promotes active participation of community based organization (CBOs) to support community health activities and includes measures to maintain motivation of CBOs by facilitating income generating ventures. Furthermore, the Project has a component of strengthening planning and financial capacity of LDHMT and health centres.

5. Appropriateness of selecting target group	-Appropriateness of selection of target group in terms of need, scale, & gender balance	-Action Plan of LDHMT -Interview with C/P & experts	As mentioned earlier, the group of under 5 children is the most vulnerable group. Scale of the Project and, accordingly, the coverage of the target group's population is expanded from one compound to six compounds to fully utilize the experience of Phase 1.
6. Spillover effect on non-target group			[Spillover effect on non target group, especially in environmental health activities] In addition, it could have spillover effect on the non-target group as it includes the component of environmental health activities, whose positive impacts are not confined to the target group alone. As there are several target compounds, where the water supply systems was or is going be constructed, the synergy effect for reducing illness can be expected.
7. Relevance to cooperation policy of Japanese government	-Cooperation policy	-Website of the Ministry of Foreign Affairs of Japan	[Ministry of Foreign Affairs of Japan] The Ministry of Foreign Affairs of Japan identifies the priority development issues for assistance to Zambia: (1) poverty alleviation, (2) structural reform of economy, (3) human resource and institutional development, and (4) environmental conservation and natural disaster. Poverty alleviation includes (a) enhancement of health care services with special emphasis on HIV/AIDS, cost efficient services, nutrition improvement, and better access to water and (b) improvement in urban environment by achieving the balanced development in rural and urban areas and adopting the direct measures to improve the urban environment. Human resource development focuses on efficient government functions as one of the priority areas. The Project can contribute to the enhancement of heath care services, improved urban environment, and efficient government administration. 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.
8. Appropriateness of LDHMT as C/P organization	-Managerial and technical ability	-Interview with C/P	LDHMT is officially assigned the role and responsibility in health care services in Lusaka district. Cap 535 part III of the National Health Services Act of 1995 (also from Act No. 14 of 1985) empowers the Ministry of Health to establish a management board for any governmental hospital or heath services. For this reason, Lusaka District Management Board (LDHMB) exists and functions to manage health services in the district. Lusaka District Health Management Team (LDHMT) is the Secretariat of the LDHMB, which have the responsibility of delivering health care services in the district.

2. Effectiveness

<table>
<tr><th>Evaluation Item</th><th>Survey Item</th><th>Means of verification</th><th>Result</th></tr>
<tr><td>1. Prospect of achievement of the Project Purpose</td><td></td><td>-Project report
-Interview with experts & C/P</td><td>The Project has made a significant achievement to improve the health status of under 5 children. The cases of non-bloody and bloody diarrhea and malnutrition declined by nearly 50%. Incidence rate of measles decreased by more than 90%. This drastic decrease of measles was realized by the National Measles Campaign in July 2003. Lusaka District performed exceptionally well by utilizing experience of GMP+ such as active community participation.

The decrease in the cases of diarrheas can be associated with the achievement of Output 1 and 2. Although knowledge of caretakers on prevention of diarrhea does not show improvement, an increasing number of households treat and keep water in proper manner such as boiling and chlorination of water. The reduction in diarrhea also has positive impact on the reduction in malnutrition.</td></tr>
<tr><td>2. External condition from outputs to Project Purpose</td><td></td><td></td><td>[Purchasing power of household income does not decrease significantly. (Economic status is not changed so much]
The economy of Zambia is relatively good in recent years due to sufficient food production, especially maize production because of good weather in 2003 and 2004 and increased international price of copper. However, the high price of crude oil has been negatively influencing its economy, which forces the Zambian government to retrench the budget. (Ministry of Foreign Affairs of Japan)

The Gross National Income (GNI) per capita shows a steady increase at current US$, though it does not necessarily mean improved living conditions due to high inflation in the past few years.

Table: GNI per capita, inflation, and population growth
<table>
<tr><th>Year</th><th>GNI per capita[1] (current US$)</th><th>Inflation[2] (annual %)</th><th>Population growth (annual %)</th></tr>
<tr><td>2000</td><td>320</td><td>30</td><td>2</td></tr>
<tr><td>2001</td><td>330</td><td>24</td><td>2</td></tr>
<tr><td>2002</td><td>340</td><td>20</td><td>2</td></tr>
<tr><td>2003</td><td>380</td><td>19</td><td>2</td></tr>
</table>
Source: World Development Indicators Database</td></tr>
</table>

[1] GNI per capita (formerly GNP per capita) is the gross national income, converted to U.S. dollars using the World Bank Atlas method, divided by the midyear population.

[2] Inflation as measured by the annual growth rate of the GDP implicit deflator shows the rate of price change in the economy as a whole.

The price of staple food (mealie and maize) in January 2005 is lower than 2003, but higher than 2004. According to the Living Conditions Monitoring Survey (LCMS III) 2002/2003, those households in Lusaka province use 46% of the total expenditure for food, 32% for non food, and 16% for rental. It implies that price hike of staple food would definitely hard hit poor households, which is likely to result in decreased spending on other items such as education and health.

Table: Trend of food price (unit: Kwacha)

Item	2003/1	2004/1	2005/1
Mealie (white breakfast 25kg)	43,127	29,791	34,679
Mealie (white roller 25kg)	38,517	21,838	27,156
White maize 20 litter tin	22,771	15,000	14,055

Source: Central Statistical Office of Zambia, "The Monthly", January 2005
Note: Figures of 2003 and 2004 are those of Lusaka province.

Ministry of Agriculture and Cooperatives would ban the export of maize for securing the food in Zambia based on the forecast of poor rain of this year (Times of Zambia, March 4, 2005). During the period from April 2004 to February 2005, over 33,901 tonnes of maize (the value of K 27.5 billion) were exported to other countries. This action may ease food shortage and price hike, which are expected as a result of poor rainfall.

The general feeling of the compound residents is that the population is increasing, which increase the competition for earning opportunities and the rent and price of houses as well. Although it is difficulty to quantify the impact on the living condition of these factors, the situation does not seem to be improving and may be even worsening, especially the poor family.

Increase of population also implies the increased number of caretakers and under-5 children to be targeted, which may give additional burden on the workload of health center staff and CBOs.

[Prevalence of HIV/ AIDS is not worsened so much]
HIV prevalence in urban areas is more than twice as high as in rural areas (23.1% and 10.8%, respectively). It indicates that high prevalence of HIV/AID would have a possibility to negatively influence on child health in that children may be infected with HIV virus from parents and there would be no one who take care of children due to death of parents and relatives.

Table: HIV Prevalence among women and men aged 15-59

Characteristics	Women (15-49)	Men (15-59)	Total
Rural	12.4	8.9	10.8
Urban	26.3	19.2	23.1

Source: CSO, CBoH, ORC Macro, "2001-2002 Zambia Demographic and Health Survey"

			According to the interview in the compound, there are indeed cases that grandparents or older sisters are caretakers of under-5 children and participate in GMP+ activities. The situation may negatively influence the health condition of under-5 children as grandparents may not have enough income to raise grandchildren. There is a possibility of positive action taken by the Government toward HIV/AIDS. The government is examining a possibility of abolishing user fee on anti-retroviral drugs (ARVs) as the system of user fees is benefiting the rich alone, who can afford to pay the fee (Sunday Times of Zambia, March 6, 2005).
3. Sufficiency of outputs to achieve the Project Purpose		-Strategic Plan	LDHMT formulated its three-year strategic plan with emphasis on the consistency between the goals of Lusaka district's health administration and support to community based health activities. Indeed, the Project's activities are an integral part of the Plan as the Plan includes GMP+ and PHAST as strategies to achieve the goals and also aims to strengthen the capacity of health management and administration. Hence the Project's activities are complementary to the goals of the Strategic Plan as well.
4. Contributing & constraining factors to achievement of Project Purpose		-Project report	[Campaign of measles vaccination] As mentioned earlier, there is an external contributing factor to a reduction in measles. In 2003, a nation-wide campaign for measles vaccination was organized. This campaign significantly contributed to 100% coverage of immunization and, as a result, a reduction in incidence rate of measles of under 5 children.
			[Combination of GMP+ and environmental health] The effectiveness of the combination of GMP+ and environmental health activities is typically shown in the reduced incidence of diarrhea and cholera. Health education at GMP+ sites and the promotion of using safe water through environmental health activities could improve the knowledge on diarrhea of caretakers and increase the use and proper storage of safe water.
			[Unavailability of soya bean products in local market] GMP+ activities are promoting soya bean as nutritious food for children. However, there is an observation that soya bean products are not readily available in the local markets. Though soya bean products may not be daily staple food, this unavailability in addition to insufficient income to purchase to soya bean products may work as a constraint against achieving more frequent intake.

3. Efficiency

Evaluation Item	Survey Item	Means of verification	Result
1. Achievement of Outputs	Achievement of Output 1	-Interview with C/P & experts -Interview with donors	Community-based child growth promotion has been enhanced through the implementation of GMP+ activities, which resulted in the improvement of indicators of this output. The ratio of under 5 children who are below the lower growth line has improved to some extent, from 14.8% to 12.3%, though there is a variance between six catchment areas in the level of achievement. The proportion of (1) fully immunized 12-23 month children and (2) the ratio of children who completed full vaccination before one year old show different results among the compounds. Although there are several factors that led to this situation, it should be noted that the immunization coverage of George compound achieved an increase in the coverage by 13% according to the statistical analysis based on the age-specific data. The frequency of weighing children for growth monitoring show some improvement as the weighing is administered by Community Health Workers. The ratio of caretakers who have adequate knowledge on prevention of diarrhea declined from 46.2% to 34.8%, while that of prevention of malnutrition improved from 32.4% to 42.1%. As the decline of the former seems to be contradicting the improved incidence rate of diarrhea, the reasons need to be explored. As more caretakers obtained better knowledge on prevention of malnutrition, the ratio of caretakers who introduced other food than breastfeeding after six months accordingly improved.
	-Taskforce meeting -Stakeholder meeting	-Interview with C/P & experts	[Taskforce committee for community based child growth promotion] The taskforce committee on community based child growth promotion (CBCGP) is held quarterly to monitor GMP+ activities and revise the guidelines. (MR4) The taskforce is organized with 20 members from the central government, NGOs, and the academic sector in addition to LDHMT and health center staffs. According to the interview with LDHMT staff, the majority of them see the taskforce on CBCGP and others as well as useful to share the information. [Stakeholder meeting] The first stakeholder meeting on child health was held in March 2004, with the participation of MoH, CBoH, donors, and other organizations. The meeting is aimed to share and disseminate information on the output and impact of community based health activities. In addition, feedback of the participants, combined with the achievement, contributes to more effective implementation of health policy and administration and more coordinated implementation of activities. (MR4)

<table>
<tr>
<td>-Under-2 children registration</td>
<td></td>
<td>[Household survey for under-2 children registration]
Complete enumeration was done in some of the compounds. All of under-2 children were registered based pm the data from complete enumeration. (MR3 p.2)

Registration of under-2 children is intended to provide detailed health care services, thereby increasing the participation of those children in GMP+, decreasing of the ratio of vaccination default, and providing care to low-weight children. (MR4)

Table: Progress of complete enumeration
<table>
<tr><th></th><th>Status (year of completion)</th></tr>
<tr><td>Chawama</td><td>Completed (2004/5)</td></tr>
<tr><td>Chipata</td><td>-</td></tr>
<tr><td>George</td><td>Completed (2002/11)</td></tr>
<tr><td>Kanyama</td><td>Completed (2004/6)</td></tr>
<tr><td>Mtendere</td><td>-</td></tr>
<tr><td>N'gombe</td><td>Completed (2002/12)</td></tr>
</table>
As the information collected is too large, the types of information to be included are going to be simplified.</td>
</tr>
<tr>
<td>-Manuals & guidelines</td>
<td></td>
<td>[Manuals and guidelines]
Operational Guideline on Growth Monitoring Programme Plus (GMP+), Nutrition Promoters Manual, and Training Guide for Nutrition Promoters were completed in 2003. (MR2 p.1)

Orientation workshop was held for GMP+ in April 2003. The 8th task force meeting, which was held in June 2003, reviewed and revised the guidelines. (MR2)</td>
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<tr>
<td>-Training of trainers</td>
<td>-Interview with C/P trained
-Interview with Experts
-Focus group discussion with CHWs & NPs</td>
<td>[Training of trainers on community health]
A 15-day training program was organized in 2003 and 2004 for health centre staff who assume to be responsible for training CBOs as a trainer and supervision and management of community health activity. After trained, trainers are expected to engage in activities for coordination, guidance, and supervision of community based activities as "community health coordinator". (MR4)

Table: Number of trainers trained
<table>
<tr><th></th><th>2002</th><th>2003</th><th>2004</th></tr>
<tr><td>Trainers trained</td><td>-</td><td>10</td><td>16</td></tr>
</table>
Some of participants in the training of trainers joined from Makeni, Klingalinga, Mandev health centers with the funding of LDHMT. This is an indication of LDHMT's commitment to community health activities and its effort to sustain the activities after the completion of the Project.</td>
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<tr>
<td>-Selection of CHWs & NPs</td>
<td>-Focus group discussion with CHWs & NPs
-Interview with HC staff</td>
<td>[Selection of CHWs and NPs]
Selection criteria of CHW were revised to reduce the dropout rate and was informed to those in charge of selection to comply with them. At the same time, the information on the recruitment of CHWs was disseminated to communities in advance, which resulted in more application from those who are equipped with more volunteerism and commitment. (MR2 p.3)

Careful attention was paid to the selection of candidates for CHWs in order to select those candidates who are committed to community development and volunteerism. The selection was made in line with the guideline. (MR4)

According to the interviewed health center staff and CBOs, the drop out rate seems to have decreased. However, many of the interviewed CBOs also referred to a constant drop out mainly due to economic reason (e.g. finding a job).</td>
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<tr>
<td>-Training of CHWs & NPs</td>
<td>-Focus group discussion with CHWs & NPs
-Interview with HC staff</td>
<td>[Training of CHWs and NPs]
CHWs are trained by using a manual produced by CBoH, while NPs are trained by a manual developed by the Project.

The Project newly trained 165 CHWs and 153 NPs in 2003 and 2004.

[Number of trained CHWs and NPs]
Table: Number of newly trained CHWs
<table>
<tr><th></th><th>2003</th><th>2004</th><th>Total</th></tr>
<tr><td>Chawama</td><td>24</td><td>23</td><td>47</td></tr>
<tr><td>Chipata</td><td>-</td><td>25</td><td>25</td></tr>
<tr><td>George</td><td>23</td><td>-</td><td>23</td></tr>
<tr><td>Kanyama</td><td>23</td><td>-</td><td>23</td></tr>
<tr><td>Mtendere</td><td>-</td><td>23</td><td>23</td></tr>
<tr><td>N'gombe</td><td>24</td><td>-</td><td>24</td></tr>
<tr><td>Total</td><td>94</td><td>71</td><td>165</td></tr>
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</td>
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</table>

Table: Number of newly trained NPs

	2003	2004	Total
Chawama		23	23
Chipata		24	24
George	27		27
Kanyama	27		27
Mtendere		27	27
N'gombe	25		25
Total	79	74	153

Although the number of sample is small and the answer is self evaluation, the majority of newly trained CHWS and NPs think they could understand completely (more than 90%) or almost completely (70-90%).

Table: Self evaluation of understanding level of the training

Level of understanding	Completely	Almost completely	More than half	Less than half	A little
CHWs	4	4	1	0	0
NPs	3	5	0	0	0

Note: Completely (understood more than 90%), almost completely (70-90%)
More than half (50-70%), less than half (40-50%), a little (less than 30%)

Almost all of the respondents to the questionnaire survey feel the need for additional or more advanced training.

Table: Need for additional or more advanced training

	Yes	No
CHWs	8	0
NPs	7	1

Refresher workshop (follow up trainings) have been organized to CHWs and NPs in six catchment areas on monthly basis seven times between September 2002 and March 2003 and twelve times between April 2003 and March 2004. The half of the cost of the monthly trainings from April 2003 was borne by LDHMT.

[Capacity to administer training programs]
In Phase 1, the Project could organize CHW training program twice at maximum. However, the Project, with more input and contribution of the LDHMT and counterpart staff, can organize them eight times biannually.

-GMP+ activities

-Interview with caretakers in GMP+ sites

[Evaluation of GMP+]
It seems generally agreed that the number of GMP+ sites and the number of caretakers who join are increasing in number at faster pace than other areas outside the Project.

Table: GMP attendance rate based on catchment areas in Lusaka District

	1999	2003	Change
Project areas	38.6%	86.9%	+48.3%
Other areas	42.1%	56.8%	+14.7%

All of the caretakers interviewed in GMP+ sites of N'gombe and George answered that they regularly attended GMP+ activities monthly to monitor the growth of their children, gain knowledge, and prevent child illness. They recognize a continuous increase of those caretakers who attend GMP+ activities and more congestion at the sites. Contributing factors for regular participation include (1) proximity to their houses and (2) existence of CBOs who are their acquaintance.
All of the interviewees recognize improvement in knowledge about child health, hygiene, and family planning. They refer to the importance of vaccination, prevention and detection of child illness, proper child feeding method as useful knowledge. They also can learn family planning as well.

The interviewees they understand the importance of the instructions given at the sites and are trying to follow it. For example, if they do not have money to purchase charcoal for boiling water and chlorine for chlorinating water, they use an alternative method, namely use of sunlight.

Furthermore, caretakers recognizes improvement in the health condition of their children as well, namely reduction of cases of illness such as diarrhea and pneumonia.

Some of the NHWs and NPs interviewed referred to the necessary material for megaphone and rain coat.

Some complained of difficulty in continuing soya bean promotion as money for purchase of soya bean is not available. The reason that such situation occurred despite of the provision of seed money by the Project is that the sales of soyabean at the GMP+ sites is slow and that rats eat soyabean at storage place.

		GMP+ is a potential and useful medium to convey important health messages including HIV/AIDs to caretakers in an efficient manner (i.e. substantially littler extra cost). In particular, if health education is conducted with a request to disseminate to other family members, it could have a significanct positive impact on improved knowledge and behavioral change of community people.
-Campaign		[Campaign] Campaigns are occasionally organized for "soya bean recipe competition" and "health baby competition". The campaign is motivating and increasing the interest in the activities.
-Joint coordinating committee	-Focus groupd discussion with CHWs & NPs -Interview with HC staff	[Joint coordinating meeting of CHWs and NPs] The joint coordinating meeting among CHWs, NPs, and the representative of health centers was initiated since September 2002. The meetings have been held quarterly in order to discuss problems and identify solutions. The meetings are evaluated as good to share the information, help each other, and learn from others, according to the interviewd CBOs. The Community Health Meeting is held quarterly with the cost sharing between the Project and LDHMT.
-Monthly workshop		[Monthly workshop] Monthly workshops are regularly organized for CHWs and NPs. The half of the cost (six meetings) is borne by the Project, while the remaining half by LDHMT.
-Follow up for GMP+ defaulters	-Focus group discussion with CHWs & NPs -Interview with HC staff	[Follow up activities for non participants in GMP+ and vaccination] There are some cases that caretakers fail to come to GMP+ sites for various reason, though economic reason (busy for finding job and money). If such case occur, CBOs make home visit as a follow-up activity to facilitate attendance.

<table>
<tr>
<td>-Monitoring and evaluation</td>
<td>-Interview with C/P trained
-Interview with Experts
-Focus groupd discussion with CHWs & NPs</td>
<td>[Monitoring and evaluation]
Evaluation and planning workshops were held in each of the six health centers' catchment areas in order to evaluate the activities of 2002 and prepare plans for 2003. These workshops were also aimed to incorporate the community level plans into the LDHMT's plan and strengthen the support of LDHMT to communities.

Performance Assessment for Improvement (PAI) was introduced as a monitoring system to improve the services of GMP+. Under this system, a monitoring team organized by the LDHMT staff monitors and evaluates the activities of GMP+ based on the items of monitoring sheet quarterly. The result of assessment is utilized to give feedback to improve the improvement of activities.

Quarterly GMP+ PAI started from September 2003 and was conducted in May and July 2004. Effort to improve monitoring and evaluation capacity was started at health center level as well. Monthly monitoring meeting for community health coordinators started since February 2004.

Table: Improvement in performance scores of GMP+
<table>
<tr><td></td><td>2003/9</td><td>2004/4</td></tr>
<tr><td>Chawama</td><td>32</td><td>63</td></tr>
<tr><td>Chipata</td><td>32</td><td>69</td></tr>
<tr><td>George</td><td>65</td><td>90</td></tr>
<tr><td>Kanyama</td><td>18</td><td>69</td></tr>
<tr><td>Mtendere</td><td>50</td><td>67</td></tr>
<tr><td>N'gombe</td><td>28</td><td>80</td></tr>
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Source: PAI (2003, 2004)</td>
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Achievement of Output 2	-Project report -Interview with C/P and experts	Community-based environmental health activities have been implemented by applying PHAST approach and promoting health education. Although behavioral change in personal hygiene can be observed, the impact deriving from construction and use of facilities seems to be limited due to the limited number and coverage of such intervention. All of six catchment areas except N'gombe have good access to water with more than 80%. The improvement in access to water in N'gombe is likely to be achieved by the construction of a water supply system through the grant of the Government of Japan. Change of behavior to make safe water through boiling or chlorination and keep water in a proper manner is evident from the data. This is a contributing factor to a reduction in incidence rate of diarrhea. The ratio of proper garbage disposal by using rubbish pit or midden box has not substantially improved. The delay in installing garbage containers made it difficult for CBOs to transport the garbage from the containers to the dumping sites. The ratio of households washing hands in a recommended manner has significantly increased from 13.6% to 28.7%. On the other hand, the use of latrines has changed slightly from 86.7% to 88.2%. Though the Project funded the construction of 10-30 VIP toilets in each catchment area, it is still small compared with the population and had a difficulty in producing a significant change of the ratio.
-Taskforce meeting -Stakeholder meeting	-Project report -Interview with C/P and experts	[Taskforce committee for PHAST guideline and manuals] Taskforce committee for PHAST guideline and manuals was established with representatives from the central government, NGOs, and the academic sector. The taskforce meeting is organized monthly in principle, providing important opportunities to share knowledge and experience of PHAST-based activities in addition to production guidelines and manuals. The taskforce committee gathered for the first time in December 2002 and held four times. [Stakeholder meeting] The first stakeholder meeting for environmental health was held in January 2004. Seventy Participants joined the meeting, including MoH, CBoH, Lusaka provincial health office, Lusaka City Council, and directors of other provinces and districts. PHAST manuals and guidelines and environmental health activities in George compound were introduced at the meeting. The second stakeholder meetings was organized in November 2004 with 60 participants and reported the progress of environmental health activities.

<table>
<tr>
<td>-Manuals and guidelines</td>
<td>-Interview with MoH & CBoH</td>
<td>[Manuals and guidelines]
PHAST Tool Manual, PHAST Field Manual, and Guidelines on Monitoring & Evaluation on PHAST were produced in close cooperation with CBoH, which resulted in its appreciation and high recognition on these manuals and its future plan in utilizing them outside the Project area.

These manuals were also revised based on the feedback from the workshops held in N'gombe and Kanyama in December 2003. The PHAST workshop in Chawama, Chipata, and Mtendere used revised manuals. PHAST Tool Manual (Part 1&2) was first used in the PHAST workshops in N'gombe and Kanyama.

The contents of organizational management, accounting, and proposal preparation are planned to be newly added to the manuals. In addition, the possibility of introducing the package of training programs (PHAST workshop, organizational management, and implementation of environmental health activities) is being considered. (MR3 p.2)</td>
</tr>
<tr>
<td>-PHAST facilitator training</td>
<td></td>
<td>[PHAST facilitator training]
Ten-day PHAST facilitator training was held in June 2003 for 30 staff from LDHMT and health centers.

Table: Number of PHAST facilitator trained
<table>
<tr><th></th><th>Duration</th><th>Number</th></tr>
<tr><td>2003/6</td><td>10 days</td><td>13</td></tr>
</table>
LDHMT allocated their own budget to PHAST facilitator training for the staff of the health centers outside the Project sites. (MR2)</td>
</tr>
</table>

-PHAST workshop	-Project report -Focus groupd discussion with EHC members	[PHAST workshop] Seven day workshops were organized in each of the six compounds except George compound.. Table: PHAST workshop

	Participant	Year/month
Chawama	30	2004/11
Chipata	30	2005/1
George	-	-
Kanyama	30	2004/2
Mtendere	30	2004/12
N'gombe	34	2003/12

Table: Self evaluation of understanding level of the training

Level of understanding	Completely	Almost completely	More than half	Less than half	A little
	2	4	3	1	0

Note: Completely (understood more than 90%), almost completely (70-90%)
More than half (50-70%), less than half (40-50%), a little (less than 30%)

Almost all of the respondents to the questionnaire survey feel the need for additional or more advanced training, though technical trainings were already proviced.

Table: Need for additional or more advanced training

	Yes	No
PHAST	11	1

The majority of those interviewed who joined the PHAST training evaluated as good, there a few who referred to the need of provision of reference after the training.

The follow-up trainings were provided for VIP toilet, drainage, and vector control by the Project. Six-day technical follow-up training program was organized for each environmental health committee members, except George that received a two-day training for monitoring and evaluation on ongoing environmental health activities (29 participants) and a two-day training for VIP toilet users (25 participants). Technical training is intended to enable participants to gain necessary knowledge and skill regarding VIP toilets, drainage construction, garbage collection system, and vector control.

Table: Technical training

	Participant	Year/month
Chawama	16	2004/12
Chipata	30	2005/2
George	29+25	2002/9
Kanyama	30	2004/2
Mtendere	30	2005/2
N'gombe	34	2003/12

	-Environmental health committee -Priority activities in environmental health	-Focus group discussion	[Environmental health committees] The workshops were organized in N'gombe and Kanyama in December 2003, which led to the establishment of environmental health committees and the identification of priority needs in respective areas. The committees were also established in the remaining three catchment areas (Chawama, Chipata, and Mtendere). Environmental health committee normally have chairman, executive committee and sub committees. [Priority activities in environmental health] Table: Priority environmental health activities in six compounds

Compound	Priority activities
Chawama	10 VIP toilet, 400-meter drainage, garbage collection, water supply (borehole)
Chipata	10 VIP toilets, solid waste management, 500-meter drainage, vector control
George	30 VIP toilet (completed), Vector control, fee paying toilets, solid waste management
Kanyama	19 VIP toilets, vector control, solid waste management
Mtendere	VIP toilets, drainage, solid waste management
N'gombe	10 VIP toilets (completed), 400-meter drainage (completed), solid waste management, vector contol

Note: Additional 50 VIP toilets have been constructed with the grassroots assistance of the Embassy of Japan. Revenue from Koshu fee paying toilet in George is planned to be moved to the community basket fund account.

Though with some difference, the fee of K3,000-5,000 is collected from VIP toilet user family. One VIP toilet is usually shared by 3-5 families. Cleaning and maintenance is the responsibility of user families, while vacuuming is conducted by using the collected fee.

There are some VIP toilet users who fail to pay the fee on time (approximately 25% in the case of George). In such a case, environmental health committee members discuss with a group of uses to sensitize the importance of payment and solve its delay.

Regarding solid waste management, K1,000 is to be collected per 25kg sack.

			The charge for vector control service is K4,000 or K7,000 per room depending on the type of chemicals. In the case of Kanyama, the money collected from vector control services is first used for purchase of chemicals and the remaining money is saved at the bank account. The percentage of expenditure for incentive is approximately 5-10%. Revenue from garbage collection is to be divided to the Council (70%) and the basket fund (30%). Drainage in N'gombe seems to have some problem in the design. As the depth is not sufficient, it usually flood if rains hard. Due to a lack of understanding, people tend to throw garbage into drainage. Regarding garbage collection, in the case of N'gombe, K5,000 is collected per month. There are some users who do not pay. Some of the EHC members suggested that other stakeholders such as the police and RDC be involved in the planning process. Koshu fee paying toilet in George compound employs one supervisor and two cashiers on a six month rotational basis. Environmental health technicians serves as a secretary and treasures for environmental health committee.
	-Cholera prevention and control	-Interview with Chorela Contact Tracing Team -LDHMT data	[Cholera contact tracing team] Evaluation meeting for the cholera contact tracing team was organized in October 2002 to update the requirements for action plans. (MR1, p.7) Taking into consideration the serious impact of cholera outbreak, the steering committee on cholera prevention was organized with the members mainly from EHTs, doctors, and nurses. The committee aimed to produce a comprehensive guideline on cholera prevention to overcome the identified obstacles (delay of initial actions, lack of surveillance system, insufficient capacity of case management, delay of warning by the local administration) and provide effective solutions. The committee further organized the taskforce meeting for discussing coordination of the guideline and the five working groups to plan a concrete plan of actions: (1) EPPC/RRT, (2) case management, (3) prevention and control, (4) logistics, and (5) data management.

		The first taskforce meeting was held in July 2004, with 60 participants from LDHMT, MoH, Teaching Hospital, Provincial health department, Lusaka district government, and NGOs. Furthermore, there were more than 6,500 cholera patients reported in Lusaka district between October 2003 and May 2004, the first large outbreak of more than 6,000 cases since 1999. The Project implemented conscious raising activities on use of safe water and hygienic food, while CHWs contacted and traced the cholera patients and cleaned the houses of such patients. (MR4) The Project and LDHMT cooperated with the CDC (Communicable Disease ??) of the US in conducting epidemiological survey in order to identify the source and pattern of infection. (MR4)
-Achievement of Output 3		Community referral services have been enhanced. The ratio of caretakers who take children to health facilities immediately after detecting danger signs increased from 35.5% to 44.4%. This improvement can be attributed to improved knowledge of caretakers and detection of danger signs at GMP+ sites.
-Community referral form		[Community referral form] Community referral form was reviewed and revised by the taskforce members since September 2002. It is aimed to strengthen the capacity of CBOs for identifying the case necessary to refer to health centers. The form is expected to be finalized in March 2003. (MR1, p.8) -Community referral forms were introduced in a pilot site. Feedback from users contributed to a further revision of the form. (MR1) There is room for improvement to increase the feedback of clinical officers to CBOs as there is an opinion of the interviewees that the former tends to give the feedback to the latter infrequently because they regard such referral as not professional. This implies the need to sensitize the health center staff including clinical officers about the importance of the feedback. A guideline was completed and orientation workshop was organized in **XXX**.
-Nutrition clinic		[Nutrition clinic] Nutrition clinics operate in the premise of each health center with the main functions of counseling, health promotion, and provision of vitamin supplement and nourishing food. The staff of nutrition clinics counsel caretakers with under 5 children who are identified as underweight, malnourished, or sick at GMP+ sites, community, and the health centres. Soya bean products or milk powder (provided by Salvation Army) are given to supplement nourishment.

<table>
<tr>
<td>-Community health post</td>
<td></td>
<td>[Community health post]
Discussion on community health posts has been regularly held with LDHMT since 2003. The issues of discussion include purpose, function, and location for construction of health posts. (MR2, p.3)
The Project and LDHMT reached a consensus on the function of a health post. The post is to have both curative and preventive services, though the majority of the services focus on the latter. It is also expected to run a business like drug store, sales of mosquito net and chlorine. Health center staff is assumed to be stationed at a post.

Table: Progress of health posts
<table>
<tr><th>Compound</th><th>Status of progress</th></tr>
<tr><td>George</td><td>A health post building is already constructed with the assistance of AMDA. Community based activities have already started.</td></tr>
<tr><td>Kanyama</td><td>A health post building is almost completed and is waiting for electricity. Procurement of necessary equipment and materials by LDHMT is delayed..</td></tr>
</table>
Note: AMDA is planning to carry out TB/HIV/AIDS-related activities, which needs to be coordinated with the Project.

Community health post was constructed in George compound with the assistance of AMDA, while the post in Kanyama was constructed with the assistance of the Project.</td>
</tr>
<tr>
<td>-Achievement of Output 4</td>
<td>-Interview with C/P & experts</td>
<td>Six health centres completed their Prioritized Action Plans and submitted to LDHMT. However, the improvement of actual funding to such prioritized actions, which is a newly added indicator of planning and financial capacity of LDHMT and health centres, remains to be seen.</td>
</tr>
<tr>
<td>-Taskforce</td>
<td>-Interview with C/P & experts</td>
<td>[Taskforce meeting for capacity building of LDHMT]
Working group for formulating the framework of the LDHMT's capacity group was established.</td>
</tr>
</table>

<table>
<tr>
<td>-Project management system</td>
<td></td>
<td>[Strengthening of Project Management System]
Project Management System (PMS) is developed to manage the activities of this Output. Under this Output, six products are going to be produced: (1) strategic plan, (2) prioritized action plan, (3) health data book plan, (4) continuous quality improvement plan, (5) financial analysis plan, and (6) information sharing plan.

PMS covers four fields (management, budget, progress, and evaluation) and uses two coding systems: Project Management System code (PMS code) and Work Breakdown Structure code (WBS code).

The coding system makes it easy for those in charge to identify the tasks to do and distinguish the completed and uncompleted tasks.

By this system, it is intended to realize (1) purposeful work environment, (2) accountable work environment, and (3) enjoyable work environment.</td>
</tr>
<tr>
<td>-Lusaka District Health Strategic Plan</td>
<td>-Strategic Plan
-Interview with C/P & experts</td>
<td>[Lusaka District Health Strategic Plan]
LDHMT's three-year Strategic Plan aims to make clear the positioning of community health activities in the strategic plan. Workshop for explaining the concept of the strategic plan was held twice in August 2003, targeting LDHMT and health center staff. Since then, weekly meetings were held to prepare the strategic plan.

Table: Progress of Strategic Plan and Prioritized Action Plan
<table>
<tr><th>Category</th><th>Schedule of completion</th></tr>
<tr><td>LDHMT Strategic Plan</td><td>2004 (completed)</td></tr>
<tr><td>LDHMT Prioritized Action Plan</td><td>2005</td></tr>
<tr><td>Prioritized Action Plan in six health centers</td><td>2005 (completed)</td></tr>
<tr><td>Prioritized Action Plan in all health centers</td><td>2005</td></tr>
<tr><td>Community Action Plan</td><td>2005</td></tr>
</table>
The Plan was completed in April 2004 with a collaborative work of Japanese experts and Zambian side for more than one-year work with weekly meetings. Priority action plan is in the process of production, based on the strategic plan. (MR4)

The Strategic Plan entails more emphasis and focus on improvement of health management system and organizational capacity, which used to be ignored in the previous annual district health action plan. This seems to be one of the impacts of Output 4.

The Strategic Plan contains another important issue, linking strategy with action.</td>
</tr>
</table>

-Prioritized Action Plan	-Prioritized Action Plan -Interview with C/P & experts	[Prioritized Action Plan] Prioritized Action Plan (PAP) aims to select priority activities and formulate the implementation plan. Workshops for PAP were organized for 4-5 times. Six health centers have already completed the PAP. Training program was organized in August and December 2004 and January 2005 to assist the LDHMT and health centre staff tin formulating the PAP. Some of LDHMT staff highly evaluates the logical way of thinking, which is required in the process of preparing the PAP. It has a potential to plan and implement prioritized activities at each level in routine work process. A manual for formulating the PAP is going to be completed in March 2005. When a briefing on the PAP was given in the workshop in 2004, a few of the health centers outside the Project area showed interest in the PAP. Indeed, they submitted the PAP based on a given form. This fact indicates a potential that the PAP can be accepted as a useful planning and management tool by health centers once it is introduced.
-Health Data Book		[Health Data Book] Health Data Book aims to strengthen administrative capacity of LDHMT on "Evidence based Management" by selecting monitoring indicators of health administration from the data in the health management information system. Workshops were held 4-5 times so far.
-Budget Plan		[Budget Plan] In November 2004, LDHMT produced its Budget Plan based on the Mid-term Expenditure Framework. This is a significant shift from a single-year budget to a multiple-year budget system.

-Continuous quality improvement	-Interview with health center staff -Interview with experts	[Continuous quality improvement] The Project introduced "Continuous Quality Improvement (CQI)" to improve operational efficiency. In July 2004, the Project provided training for quality improvement to 150 staff of LDHMT and health centers to enable them to understand its concept and methodology. (MR4) [5S] 5S (Sort, Set, Shine, Standarize, and Sustain) 5S patrol teams are organized for mutual visit between health centers and checking the condition. The guidance for conducting 5S patrol was explained in February 2005. To promote 5S activity, photo contests are held biannually and annual awarding festival is held annually. Director of LDHMT commits himself to 5S activity as he is a co-author for 5S manual with a Japanese short-term expert.
-Achievement of Output 5		Management capacity of CBOs to sustain community-based health activities is being strengthened by a series of trainings and introduction of income generating ventures. It is likely to take some time for the ventures to generate profit. The ratio of drop out of CHWs and NPs decreased from 37.7% to 24.0%. As explained later, the strict application of the selection criteria is regarded as a contributing factor. Regarding the income generating ventures, there is only one profit making venture in George (Koshu fee paying toilet) at present. There are some other ventures under preparation, such as Koshu fee paying toilet in Chawama and hammer mill in Chawama, Kanyama, and N'gombe.

	-Neighborhood health committee	-Interview with neighborhood health committees	[Election of neighborhood health committee] Neighborhood Health Committee (NHC) is an integral part of the service system to link the health centre and the community. NHC mobilizes the community in prioritizing health needs and implementing the activities. The Project has been supporting the election and capacity building of NHC members. Table: Election of and training to NHC

	Election	Training	
		Year/month	Number
Chawama	-	-	-
Chipata	-	-	-
George	2002/9	2002/10	100
Kanyama	-	-	-
Mtendere	2004/7	2004/8	116
N'gombe		2004/6	80

[Strengthening of NHC]
Two-day orientation workshop and one-day training program in basic health care services are provided to newly elected NHC members.

In the case of George, the taskforce team was established to review the roles and responsibilities of NHC and to reelect the NHC members. Re-election of NHC in George compound was held in August 2002 after the sensitization in all the units of George compound. The orientation was held in October 2002 for new NHC members on its role and responsibility. (MR1, p.9)

Some of the interviewed NHC members gave a critical opinion on the eligibility for membership. Some of the elected NHC members lack background and knowledge in community health and are unable to adequately conduct their tasks such as monitoring activity. This is one of the reason for the existence of inactive members.

<table>
<tr>
<td></td>
<td>-Community basket fund</td>
<td></td>
<td>[Community basket fund]
Income generative ventures are regarded as an effective means to solve the problem of incentive and generate the money for sustaining and expanding community health activities.

There are several ongoing and planned income generating ventures under the management of a community basket fund committee.

Table: Activities of community basket fund committees in six compounds
<table>
<tr><th>Compound</th><th>Status of income generating ventures</th></tr>
<tr><td>Chawama</td><td>Koshu fee paying toilet (under construction), hammer mill</td></tr>
<tr><td>Chipata</td><td>-</td></tr>
<tr><td>George</td><td>Koshu fee paying toilet (making profit), hammer mill (operating)</td></tr>
<tr><td>Kanyama</td><td>Koshu fee paying toilet, hammer mill (equipment is not installed yet, waiting for electricity)</td></tr>
<tr><td>Mtendere</td><td>-</td></tr>
<tr><td>N'gombe</td><td>Hammer mill (electricity capacity needs to be increased for operation)</td></tr>
</table>
Note: Koshu toilet in George charge K400 for toilet and K1,000 for shower.

Community basket fund was introduced in George compound. Community basket fund committee was established as well to establish a system to save money by the profit of such activities as Koshu fee paying toilets. Community basket fund committee consists of representatives of CBOs and a health center. The committee is also established in Kanyama, Chawama, N'gombe.

Koshu fee paying toilet is currently only one profit making income generating activity under the Project. It is currently producing a net profit of $250 per month, half of which is deposited to the community basket fund. So far, $1,500 was deposited. (MR3, p.3)
On the other hand, hammer mill does not seem to be producing profit yet because maize is not abundantly available at present.</td>
</tr>
<tr>
<td>2. Sufficiency of activities and inputs to produce Outputs</td>
<td></td>
<td>-Result of PDM workshop</td>
<td>The Project organized PDM workshop in March 2005 in order to review the PDM. The participants from LDHMT and health centres discussed the revision of the PDM to adjust to the reality and further improve the structure of the Project.</td>
</tr>
</table>

3. Changes of external condition from Activities to Outputs		-Interview with C/P & experts -Interview with MoH & CBoH	[Assurance of steady supply of essential drugs, equipment, consumables vaccines and micronutrients from EDMSS] Stable supply of EDMSS is an important assumption to be met. Although Action Plan and Budget for 2005-2007 of Lusaka District Health Management Board states that the supply of EDMSS was often inadequate and erratic, essential drug kits have been already provided to LDHMT. LDHMT had to spend its own budget for purchase of supply, which often goes beyond 4% ceiling imposed on emergency drugs. Although sufficient materials necessary for GMP+ activities are stably supplied according to LDHMT and health centre staff, the situation needs to be continuously and carefully monitored.
			[Budget is disbursed from central level timely.] Implementation of planned activities depends on the disbursement of the fund. In this respect, the government allocates 12% of the total budget to the health sector in 2005, which is an increase from 10.5% in the previous fiscal year.
			[Coordination between other projects is secured] Coordination with other project has been done. The demarcation of the activity areas between the Project and CARE was an effective coordination to avoid duplication and confusion. Both of them have been implementing community based health activities in compounds of Lusaka district and agreed to divide the activities area between them to avoid the duplication of activities in the same area. This issue was discussed and approved at Child Health Taskforce Meeting, indicating the Meeting functions well as an effective coordination mechanism. (MR3, p.2)
4. Adequacy of quantity, quality and timing of inputs	-Experts, equipment, C/P, C/P training, budget allocation	-Project report -Interview with C/P -Interview with experts	[Dispatch of experts] Due to an unavoidable situation, a short-term expert on participatory methodology was dispatched later than originally scheduled. (MR1 p. 11) A long-term expert on health planning and management was also dispatched later than scheduled due to a difficulty in recruitment. [Assignment of counterpart staff] Ten staff of LDHMT are assigned as counter part staff. Six to eight staff are assigned from each of six health centers. [Counterpart training in Japan] Counterpart staff of MoH, CBoH, LDHMT, and health centres were dispatched to Japan as planned for counterpart training: 2 in JFY2002, 4 in JFY2003, and 10 in JFY2004. [Provision of equipment] Equipment was procured and provided as planned. All of the equipment except consumables are kept in good condition.

5. Cost effectiveness	-Other similar projects	-Interview with experts -Interview with donors	The Project utilizes CBOs for community health activities, which is indeed low cost based on volunteerism, not paid staff, though it is accompanied with the risk of drop out due to a lack of incentives and a resultant low motivation and commitment. 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.
6. Contributing and constraining factors to achievement of outputs and efficiency		-Project report -Interview with C/P & experts	[PDM indicator workshop] PDM indicator workshop was held in January 2003 to discuss selection of indicators and survey method. Baseline survey was conducted for one month in February and March 2003 to collect the baseline data and determine the benchmark for monitoring and evaluation. The total of 3,000 samples was collected with 500 samples in each cathment area. Furthermore, the mid-term survey was conducted with the same method to assess the achievement at the middle term of the Project.
			[More frequent training program compared with Phase 1] improved capability of the counterpart staff increased the number of trainings compared with Phase 1 of the Project. In Phase 1, training programs could be organized twice per year at maximum due to the limited capacity of counterpart staff and the time consuming process of preparation in selection of candidates for training and training of trainers. However, in Phase 2, training programmes can be organized eight times in six months, mainly by the staff of LDHMT and health centres as a result of capacity building. (MR3 p.1)
			[Decease of coverage of vaccination] There are several possible factors that negatively influenced the underachievement of immunization coverage. First, as health centre staff have more duty and work, they tend to arrive late at the site, taking more time to finish vaccination. Second, as a result, the queue at GMP+ sites tend to be long and some of caretakers leave the sites before having vaccination for their under 5 children. Third, caretakers tend to avoid a newly introduced vaccine (Hib) for their children due to a lack of proper knowledge. Fourth, the limited number of health centre staff in addition to heavier workload also constraints GMP+ activities.

[Incentive and long hours of work of CBOs]
There is a mounting frustration among CBOs regarding a lack of incentives. Many of the interviewed recognize this issue as a serious concern. Lusaka District Health Strategic Plan 2004-2006 refers to the issue of incentive, stating that CBOs are provided little and their needs on this regard are strong and consistent. Furthermore, CBOs are assumed to work for limited hours. However, CBOs tend to work much longer than the norm of two hours per day. This is partly due to the drop out of CBOs and the increasing number of caretakers attending GMP+. Long hours of work may not mean a genuine voluntary work to CBOs. Many of them expressed frustration on an absence of incentive in return for their long-hour voluntary work.

There are two different types of incentives at present. First, LDHMT pays a fixed amount of per diem to two CBO members per GMP+ site. In reality, there are more than two CBOs helping GMP+ activities, which mean they need to share a very small amount of per diem. In addition, it is quite often the case that the payment of per diem to CBOs is delayed. There is another but informal benefit of medical fee exemption for CBOs and their family members, though this seems depend on the discretion of each health center.

Income generating ventures under the Project is expected to produce profit, which can be spent for incentives, though the actual impact has yet to seen.

[Time consuming process of coordination with LDHMT in the construction of community health posts]
It took more time than initially planned to coordinate on the role of heath posts between the Project and LDHMT, which delayed its construction. While the Project assumed the role of the posts as the central base of prevention and health promotion such as intermediary point of community referral and bases of community volunteers, LDHMT additionally assumed the role of medial treatment and assignment of resident health centre staff and preferred the construction of the posts in areas with difficulty in access to health centres.

[Coordination with Lusaka district government in environmental health]
The Project and the Lusaka City Council discussed and agreed on the division of roles and responsibilities with the former responsible for enlightenment of residents and maintenance of containers and the latter for containers installation and garbage collection. However, installation of large garbage containers, which is the responsibility of the Council, is delayed due to various factors. This delay also significantly delays environmental health activities of the Project. There is some difficulty in coordination because of different supervising ministries.

[Time consuming process of collecting data for Strategic Plan 2004-2006]
It took more time than expected to collect necessary statistical data for the Strategic Plan. Due to this factor, outputs and indicators of the Plan were left out and the activities under each strategy were chosen arbitrarily by health centres.

[Strict application of criteria for selecting CBOs]
The reduction of drop out is partly attributed to the strict application of selection criteria such as literacy in English, avoiding young school leaver as candidates, and commitment to volunteer work. However, according to the discussion with CBOs, there are constant drop out due to finding jobs, becoming sick, or moving out of compounds. The issue of incentive, which tends to be associated with the reason for inactive CBOs or drop out, will be addressed by the promotion of profit-making income generative ventures, which is another indicator of Output 5.

[Constraints of human resource of health centers]
Shortage of human resource of LDHMT and health centres is a serious constraint on overall activities of the Project and routine work of LDHMT as well. The actual number of staff is not meeting the required number and the staff is constantly resigning. LDHMT recognizes the insufficient number of LDHMT staff, stating in its Strategic Plan that there is a critical shortage of doctors, clinical officers and nurses, which leads to compromised curative services, reproductive and child health programs.

Table: Number of staff

Category of staff	Required	Actual	Difference
Medical superintendent	4	4	0
Medical officers	49	28	-21
Nursing sisters	27	26	-1
Clinical officers	184	139	-45
Registered nurse	132	108	-24
Registered midwife	140	98	-42
Enrolled nurse	462	412	-50
Enrolled midwife	325	257	-68
Environmental health technician	27	26	-1
Others	134	100	-34
Total	1,484	1,198	-286

			In addition, there are many ongoing programs and projects including research projects in the District, many of which are supported by domestic and overseas organization. This seems to impose extra burden on the staff. At present, there is an imposition of the ban on the recruitment of new staff. LDHMT is spending approximately 10% of the budget (excluding the salary of the staff on payroll). There factors lead to the situation that the staff are taking multiple roles in their work for the Project, which increases the burden and may decrease efficiency in work in the future.
			[Distance and familiarity with CBOs] Many of the interviewed caretakers referred to proximity to their houses as an important advantage of GMP+ site. The factor that the majority of CBOs are their acquaintance in neighborhood is contributing to regular attendance to GMP+ activities. Such increase of number of participants further contributes to a reduction in congestion at health centres.
			[Effective management structure] The Project formulated management mechanism at each level such as Stakeholder Meeting and Joint Coordination Committee, Taskforce on Child Health and Environmental Health, and Joint Meeting. Such mechanism is effective to facilitate communication, share the information and formulate strategies.

4. Impact

Evaluation Item	Survey Item	Means of verification	Result
1. Direct impact (Overall Goal level)	-Prospect of achievement of Overall Goal	-Project report -Interview with C/P experts	There was an expansion of the Project's activities beyond the target areas by the effort and funding of LDHMT. LDHMT allocated its own budget for training programs in the catchment areas of other health centres (nutrition promoter training for five compounds and PHAST training for all of the environmental health technicians). It also introduced GMP+ activities in other three catchment areas. Although the remaining tasks are huge and the impact on improvement in child health has yet to be seen, this is a step forward to improved child health in the whole district.
2. Other impacts	-Direct and indirect impact (policy, economy, institution/ organization, technology, socio culture, environment)	-Data on cholera outbreak in Lusaka district -Comparison of data between the Project area and outside the Project	[Reduction in cholera outbreak] The reduction of cholera cases in George compound is confirmed as a result of improved environmental health through a series of activities. The cases of cholera was confirmed in December 2003 and drastically increased until the mid February 2004. While nearly 50% of the patients concentrated in Kanyama and Chawama compounds, those of George compound was small in number. Ministry of Health (MoH) and Lusaka Province made an official statement that the improvement in environmental health of George compound and behavioral change of residents significantly contributed to prevention of cholera. During this outbreak, epidemiological study was conducted by using the GIS in cooperation with EHTs and CBOs who engaged in locating the patients by GPS. This led to the production of cholera patient data map. The GIS data map made it possible to conduct statistical analysis by combining the various survey results and visualize the compound-based situation of the cholera outbreak on the map, which resulted in strengthened surveillance capacity and improved efficiency of cholera control activities. GIS data can be utilized for planning, monitoring, and evaluation in various activities, including community based environmental health activities. The recent cholera outbreak led to the establishment of the steering committee on cholera prevention and control with the members mainly from EHTs, doctors, and nurses. The committee produced a draft comprehensive guideline on cholera prevention to overcome the identified obstacles (delay of initial actions, inadequate surveillance system, insufficient capacity of case management, delay of warning by the local administration) and provide effective solutions. The first taskforce meeting was held in July 2004, with 60 participants from LDHMT, MoH, University Teaching Hospital, Provincial health department, Lusaka City Council, and NGOs.

			[Official recognition of PHAST approach by LDHMT and the Zambia government] The achievement of the Project had an influence on the approach for environmental health in Lusaka District and Zambia. First, LDHMT includes PHAST approach as one of the strategies to achieve an objective of "reducing the morbidity and mortality due to pneumonia, malaria, and diarrhoeal diseases in all ages" under Goal 1 "Reduction of the burden of illness from common diseases in the district" in the Strategic Plan. Second, Central Board of Health (CBoH) officially recognizes PHAST approach as an effective tool for environmental health. Training of trainers for PHAST approach was organized in several provinces by using the PHAST manuals developed by the Project with the funding of CBoH and UNICEF.
			[Official recognition and promotion of GMP+ as a community based activity for under-5 children by LDHMT] LDHMT includes GMP+ as one of the strategies to achieve an objective of "reducing the morbidity and mortality from childhood preventable illnesses in under 5 children" under Goal 1 "Reduction of the burden of illness from common diseases in the district in the Strategic Plan. LDHMT decided to organize training programs for nutrition promotes 3-4 times per year based on a newly developed "Nutrition Promoters Manual" in the areas outside the Project sites. The cacthment areas include Matero, Kalingalinga, Chipata, Chainda, Makeni, Mandeve. (MR2, p.4) GMP+ activity has been already introduced to three catchment areas (Matero, Chainda, Mandeve) by LDHMT's own effort.

3. Change in external conditions			[Environmental health/housing condition in the compounds in Lusaka district are not worsened] Environmental health and housing condition may continue to be worsened. As mentioned earlier, the population in the compounds seems to be steadily increasing. Although there is no available data on changes in environmental health and housing condition, all of the interviewed caretakers and CBOs recognize the increase of population in the compounds. It implies that environmental health conditions may be further worsened in the compounds, especially those areas where no major environmental health activities are implemented. This situation may seriously affect the health status of under 5 children. [Donors funding should be maintained at acceptable level] Donor funding is important source for LDHMT's activities. Although there is an increasing trend of donor funding between 2001 (K7,186.4 million) and 2002 (K9,581.8 million), it needs to be carefully monitored as changes in donor funding would significantly influence the operation of health care services in the district. Table: Budget of LDHMT (Unit: million Kwacha)

	2001		2002	
	Planned	Actual	Planned	Actual
Gov't grant	144	893.4	120	129.1
Donor	2,150.3	7,186.4	9,581.8	9,581.8
Medical fees	1,000	867.7	983.3	1,087.0
Other income	72.0	177.0	276.9	672.5
Total	3,366.3	9,124.4	10,962.0	11,470.4

Note: Salary of the staff on the government payroll and essential drugs are not included in the figure of Gov't grant..

5. Sustainability

Evaluation Item	Survey Item	Means of verification	Result
1. Technical aspects	-Technical level of C/P organization to maintain activities and system	-Interview with C/P -Interview with experts	The capability of LDHMT and health centre staff as trainers is improving. Improved knowledge and skill in conducting trainings as trainer is indicated in the increased number of trainings compared with Phase 1, mainly by the staff of LDHMT and health centres as a result of capacity building.
	-Technical level of CBOs		There is a need for organizing constant training for new and existing CBOs. There has been a constant drop out of CBOs, which necessitates the organizing of regular trainings to fill out the drop out. Monthly refresher workshop has been conducted for CHWs and NPs. Despite that, the need for additional or refresher training is still high according to the interviewed CBOs.
2. Policy/program aspects	-Prospect of replication & expansion of the Project	-Interview with ministries -Interview with experts -Interview with donors	The Project has been attempting to share the outcome of the Project with other stakeholders in order to share the experience and institutionalize the activities by organizing stakeholder meetings. There is a possibility of replication of PHAST-based environmental health activities. CBoH officially recognizes PHAST approach as a tool for environmental health. Training of trainers for PHAST approach was organized in several provinces.
3. Organizational /financial aspects	-Management capability and human resource of LDHMT		Organizational sustainability in terms of management capability of LDHMT depends much on the achievement of Output 4. LDHMT produced the three-year Strategic Plan in cooperation with the Project. The Plan sets as Goal 3 "improve the health management systems and governance structures of the district's health care delivery system". Therefore, LDHMT commits itself to strengthening of its capability on managing the district's health care delivery system. The outcome of its effort has yet to be seen with the achievement of Output 4. Human resource of LDHMT as well as financial capacity has been and is likely to continue to be a serious constraint for maintaining and expanding the Project activities and other routine activities. At this moment, there does not seem to be any short-term solution for this issue. However, at least this issue needs to be recognized by MoH, CBoH and JICA.
	-Prospect of budget allocation from LDHMT	-Interview with LDHMT	The cost sharing has been done by the Project and LDHMT. Once the Project is completed, LDHMT needs to accelerate its effort to source for funds in order to continue the current Project activities in the future. Table: Cost sharing of the Project activities

	Project	LDHMT	CBoH	Community
Training	74%	26%	-	-
Equipment and material	18%	16%	53%	13%
Personnel	0%	100%	-	-
Monitoring	100%	0%	-	-

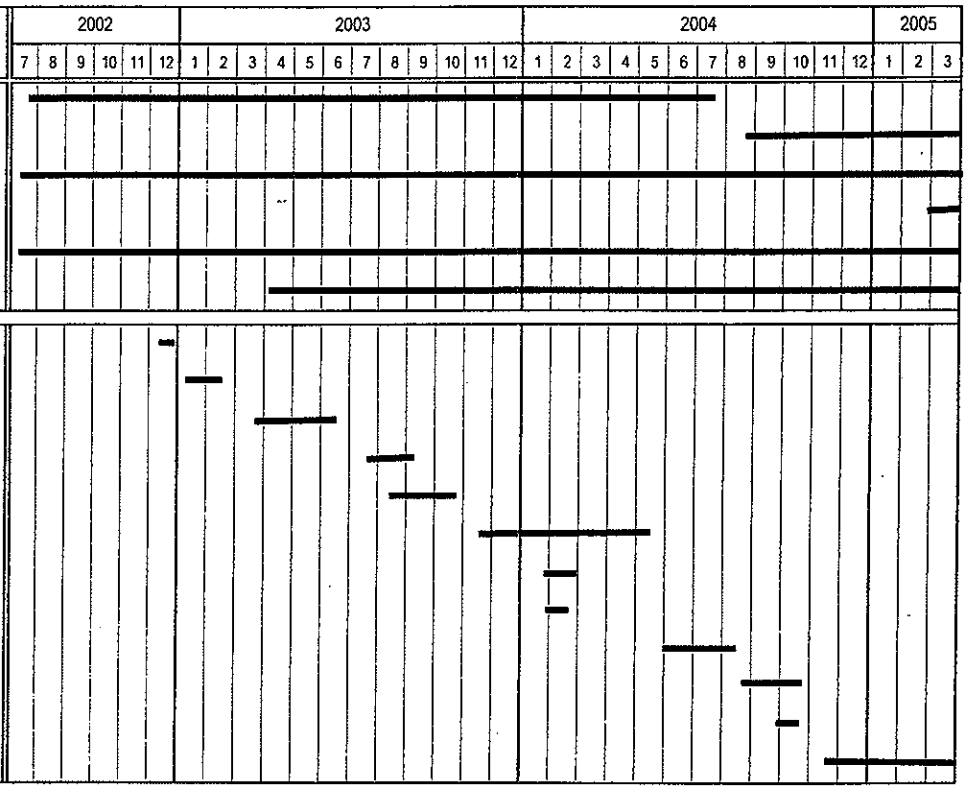
	-Incentives to CBOs		[Incentive to CBOs] The issue of incentives to CBOs is recognized in Lusaka District Health Strategic Plan 2004-2006. The Plan states that CBOs are given very little benefit and their needs on this issue are strong. If this frustration is resolved, it may have a serious negative impact on the continuation of community health activities as it depends very much on their effort. LDHMT will continue to work to the central government to institutionalize a policy on incentives to CBOs. In addition, the effort to the income generating ventures to generate the money for incentives to CBOs should be further strengthened.

Dispatch of Experts

Annex 3

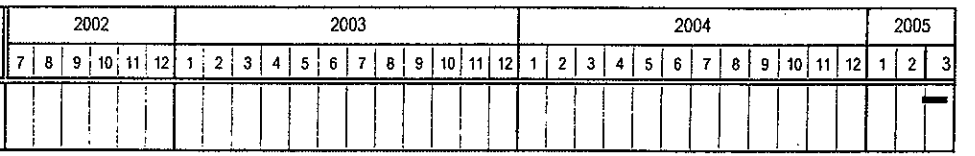
EXPERT DISPATCH

	No	Field of Expertise	Name	Period	Organisation
LT	1	Chief Adviser	NAGAKURA Takashi	2002/07/24 — 2004/07/23	ICDS
	2	Chief Adviser	YATSUBAYASHI Akio	2004/08/13 — 2006/08/12	ICP
	3	Project Coordinator	SASAKI Satoshi	2002/07/15 — 2005/04/01	M. D. International
	4	Project Coordinator	FUJINO Yasuyuki	2005/02/26 2007/07/15	M. D. International
	5	Community Health	IGARASHI Kumiko	2002/07/15 — 2005/06/30	M. D. International
	6	Health Planning & Management	MARUYAMA Seishin	2003/05/01 — 2005/07/31	
ST	7	Child Health	SUZUKI Hiroshi	2002/12/11 — 2002/12/21	Niigata University
	8	Monitoring & Evaluation	SUZUKI Shuichi	2003/01/04 — 2003/02/03	FASID
	9	Participatory Approach	FUJINO Yasuyuki	2003/03/17 — 2003/06/16	AMDA
	10	GIS	SUGITA Akihiro	2003/07/25 — 2003/09/06	Pasco
	11	Public Health Analysis	INAOKA Emi	2003/08/09 — 2003/10/17	
	12	Environmental HEALTH	OHNO Nobuko	2003/11/23 — 2004/05/22	AMDA
	13	Child Health	NAKANO Hiroyuki	2004/01/31 — 2004/02/28	St. Mery's Hospital
	14	IEC Materials	MAEKAWA Tomoyasu	2004/01/31 — 2004/02/14	JICE
	15	Organisational Managament	HANDA Yujiro	2004/05/31 — 2004/08/20	JICA
	16	Multimedia Production	TOKUMURA Tomoaki	2004/08/27 — 2004/09/25	JICE
	17	Child Health	SUZUKI Hiroshi	2004/08/29 — 2004/09/09	Niigata University
	18	Environmental HEALTH	KINOSITA Makiko	2004/10/18 — 2005/06/03	AMDA



EVALUATION TEAM DISPATCH

No	Purpose	No.	Period	
1	Mid-Term Evaluation	5	2005/02/26 — 2005/03/22	UMENAI, SUZUKI, SUGANAMI, TAKIZAWA, AZEGAMI

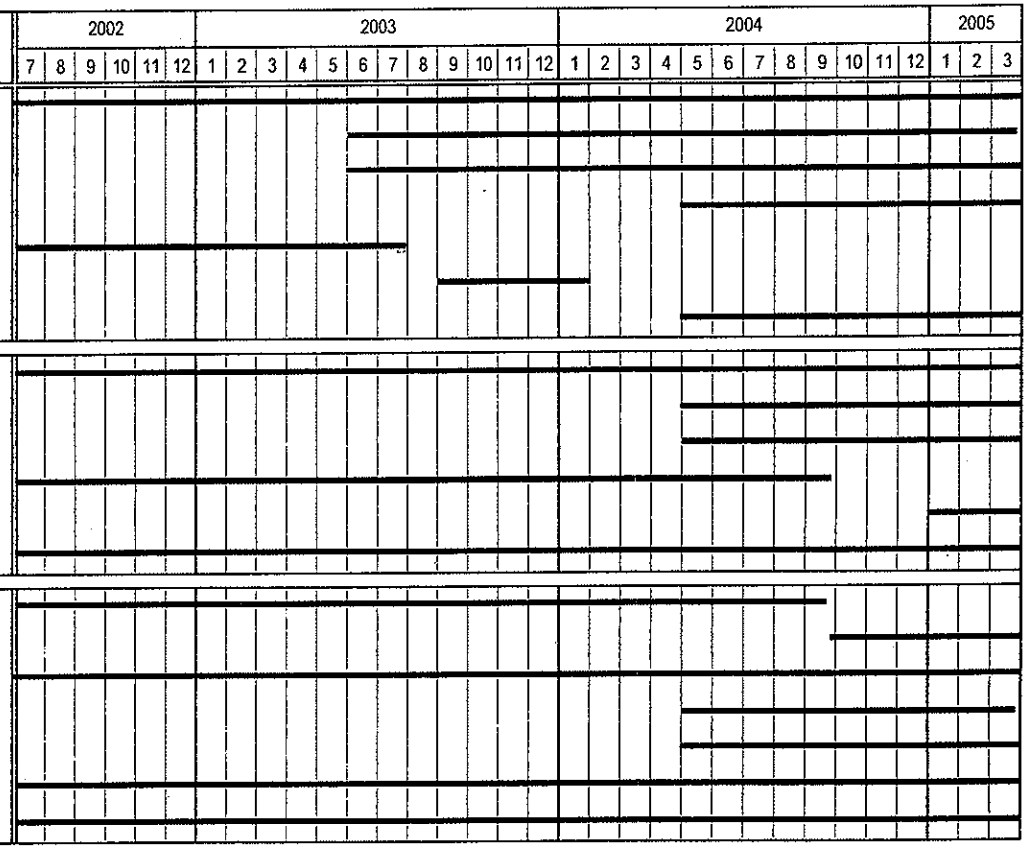


Record of C/P Allocation

Organisation/Institution	Position	Name	2002						2003												2004												2005		
			7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
LDHMT	District Director of Health	Dr. Moses Sinkala																																	
	Manager Planning and Development	Dr. Mbwili Muleya																																	
	Manager Planning and Development	Dr. Mpundu Chikoya																																	
	Manager Administration	Mr. Eddine Musonda																																	
	Mother and Child Health in charge	Mrs. Mary Banda																																	
	Environmental Health Expert	Mr. Philip Mulenga																																	
	Senior Health Education Officer	Mrs. Mavis Kalumba																																	
	Health Information Expert	Mrs. Charity Nyambe																																	
	Public Health Nurse	Mrs. Elizabeth Mushinda																																	
	Environmental Health Officer	Mr. Meetwell Chello																																	
George HC	Sister in charge	Mrs. Agness Stanzye																																	
	Clinical Officer	Mr. Jombo Kondowe																																	
	Mother and Child Health in charge	Mrs. Evelyn Tembo																																	
	Nutritionist	Mrs Albertina Kapeshi																																	
	Nurse	Mrs. Manjeta Lushito																																	
	Environmental Health Technologist	Mrs. Tamara Mwamulowe																																	
N'gombe HC	Sister in charge	Mrs. Muwana Sezongo																																	
	Clinical Officer	Mr. Ignatius Blongo																																	
	Mother and Child Health in charge	Mrs. Chileshe Shiwale																																	
	Nutritionist	Mrs. Berverly Chabwera																																	
	Nutritionist	Mrs. Prisca Sakala																																	
	Midwife	Mrs. Rosemary Chabala																																	
	Environmental Health Technologist	Mrs. Chola Chileshe																																	
	Environmental Health Technologist	Mrs. Alice Mainza																																	
Kanyama HC	Sister in charge	Mrs. Precious Handongwe																																	
	Sister in charge	Mrs. Alice Mainza																																	
	Clinical Officer	Mr. Donald Mukunbuta																																	
	Mother and Child Health in charge	Mrs. Alice Mainza																																	
	Nutritionist	Mrs. Pricscilla Chifundo																																	
	Environmental Health Technologist	Mrs. Klevina Mizanda																																	

Record of C/P Allocation

Organisation/Institution	Position	Name
Chawama HC	Sister in charge	Mrs. Stella Munge
	Clinical Officer	Mr. Pharao Njobvu
	Mother and Child Health in charge	Mrs. Anne Mwape
	Nutritionist	Mrs. Shebo Sharon
	Environmental Health Technologist	Mrs. Precious Kalubla
	Environmental Health Technologist	Mr. Joseph Yowela
	Environmental Health Technologist	Mr. Aron Njobvu
Mutendere HC	Sister in charge	Mrs. Media Chikwanda
	Clinical Officer	Mrs. Rachel Zozi
	Mother and Child Health in charge	Mrs. Susan Mumba
	Nutritionist	Mrs. Sandra Chafwa
	Nutritionist	Mr. Ephraim Mambwe
	Environmental Health Technologist	Mr. Willard Mooya
Chipata HC	Sister in charge	Mrs. Rebecca Munkonba
	Sister in charge	Mrs. Happy Chipulu
	Clinical Officer	Mr. Muzantani Bomface
	Mother and Child Health in charge	Mrs. Christin Tembo
	Midwife	Mrs. Chilba Sikazwe
	Nutritionist	Mrs. Mary Kakombo
	Environmental Health Technologist	Mrs. Jaan Mataa



Track Record of Dispatch of C/P Trainees

FY (JP)	No	Field of Training	Type	Name	Organisation/Institution	Position	Period	Training Institution
FY2002	1	Health Policy for Community Activities	Project	Dr. Mary Bwalya	CBOH	Child Health Expert	2003/02/21 — 2003/03/10	Niigata University
	2	Health Policy for Community Activities	Project	Dr. Makungu Kabaso	LDHMT	Clinical Officer	2003/02/21 — 2003/03/10	AMDA
FY2003	3	Counter-measure for Improvement of MCH indices II	Group	Mrs. Sibeso Sezongo	N'gombe HC	Sister-In-Charge	2003/04/28 — 2003/06/15	Agency for Cooperation in International Health
	4	Seminor for Health Policy Development	Group/Project	Mr. Fordson Nyirenda	CBOH	Environmental Health Expert	2004/01/25 — 2004/02/17	National Institute for Public Health, Niigata University
	5	Health Policy for Community Activities	Project	Dr. Mbwili Muleya	LDHMT	Manager Planning & Development	2004/02/15 — 2004/03/09	Niigata University, AMDA
	6	Community Health Services	Group	Mrs. Klevina Mizanda	Kanyama HC	Environmental Haelth Technologist	2004/03/22 — 2004/07/10	St. Mary's Hospital
FY2004	7	Nutrition and Diet Improvement for Women Leaders II	Group	Ms. Albertina Kapeshi	George HC	Nutritionist	2004/11/08 — 2005/02/02	Obihiro Otani Junior Collage
	8	Multimedia Production for Community Health	Project	Mrs. Evelyn Tembo	George HC	MCH-In-Charge	2004/11/17 — 2004/12/19	Okinawa International Centre
	9	Multimedia Production for Community Health	Project	Mr. Mavis Kalumba	LDHMT	Senior Education Officer	2004/11/17 — 2004/12/19	Okinawa International Centre
	10	Community Health	Project	Ms. Agness Stanzye	George HC	Sister-In-Charge	2005/02/06 — 2005/02/26	AMDA
	11	Community Health	Project	Ms. Happy Chipulu	Chipata HC	Sister-In-Charge	2005/02/06 — 2005/02/26	AMDA
	12	Community Health	Project	Ms. Media Chikwanda	Mutendere HC	Sister-In-Charge	2005/02/06 — 2005/02/26	AMDA
	13	Data Analysis for Community Health	Project	Mr. Meetwell Cheelo	LDHMT	Environmental Health Technologist	2005/02/06 — 2005/02/20	Niigata University, AMDA
	14	Community Health Services	Group	Ms. Alice Mainza	Kanyama HC	Sister-In-Charge	2005/03/21 — 2005/07/16	St. Mery's Hospital
	15	Health Administration	Project	Mr. Davis Chimfwembe	MoH	Director, Planning	2005/02/20 — 2005/03/05	Niigata University, International University of Health and Welfare, AMDA
	16	Community Health Administration	Project	Dr. Mpundu Chikoya	LDHMT	Manager Planning & Development	2005/04/02 — 2005/04/17	Niigata University, AMDA

Track Record of Provision of Equipment

FY (JP)	No	Item	Qty	Price	Manufacturer	Model	Date of Asset Entry	Location	Utilisation	Maintenance
FY2002	1	photocopier	1	1,043	CANON	NP6330	2003/03/18	LDHMT / JICA-PHC Office	A	A
	2	application soft	1	212	ESRI	Arcview 8.1	2003/03/13	LDHMT / JICA-PHC Office	C	A
	3	application soft	1	369	ESRI	Spatial Analysis	2003/03/18	LDHMT / JICA-PHC Office	C	A
	4	GIS	2	187	GARMIN	GPSMap 76S	2003/03/28	LDHMT / JICA-PHC Office	C	A
	5	babay hanging scale	30	340	SALTER		2003/03/19	6 HCs	C	A
	6	adult weighing scale	30	52	SALTER		2003/03/19	6 HCs	C	A
	7	syringe (2 ml)	60,000	259			2003/03/19	6 HCs	D	D
	8	needles (23G)	60,000	180			2003/03/19	6 HCs	D	D
	9	shelter tent	7	328			2003/03/25	LDHMT / JICA-PHC Office	C	A
	10	bycycle	12	125	HAMILTON	MTB	2003/03/22	6 HCs	A	A
FY2003	11	GIS data of Lusaka District	1	3,350	PASCO		2003/07/25	LDHMT / JICA-PHC Office	C	A
	12	computer	1	290	TOSHIBA	Satellite 5200	2003/07/25	LDHMT / JICA-PHC Office	A	A
	13	electric hammer mill	8	2,503	DROSTSKY	Electric S6	2004/02/27	George Compound / JICA-PHC Office	A	A
	14	portable water testing kit	6	1,444	WAGTECH	Potakit 1	2004/03/05	6 HCs	A	A
	15	computer	2	503	COMPAQ	Evo D330	2004/03/19	LDHMT / JICA-PHC Office	A	A
	16	vehicle	1	2,868	MITSUBISHI	Pajero 300DL	2004/03/22	LDHMT / JICA-PHC Office	A	A
	17	copy printer	1	2,685	GESTNER	5450	2004/03/02	LDHMT / JICA-PHC Office	C	A
	18	examination table (for HP)	1	20			2004/03/18	LDHMT / JICA-PHC Office	C	A
	19	shelf (for HP pharmacy)	1	22			2004/03/22	LDHMT / JICA-PHC Office	C	A
	20	table (for HP)	2	40			2004/03/18	LDHMT / JICA-PHC Office	C	A
	21	chair (for HP)	2	22			2004/03/22	LDHMT / JICA-PHC Office	C	A
FY2004	22	computer	5	937	HP	DX6100	order released	—	—	—
	23	projector	1	211	SONY	VPLCS6	2005/02/09	LDHMT / JICA-PHC Office	C	A
	24	vehicle	1	3,130	TOYOTA	Land Cruiser 4.2	order released	—	—	—
	25	GPS	12	1,065	GARMIN	GPSMap 76CS	order released	—	—	—
	26	application soft	2	370	ESRI	Arcview 9	2005/01/31	LDHMT / JICA-PHC Office	C	A
	27	electric hammer mill	4	1,224			order released	—	—	—
	28	first aid kit	180	475			order released	—	—	—
	29	ORS	20,000	258			order released	—	—	—

Utilisation:
A: daily
B: twice/three time a week
C: used on requirement
D: used

Maintenance
A: good condition
B: out of order (repairable)
C: out of order (unrepairable)
D: used

Track Record of Traininig and Activities

FY (JP) 2002

Y	M	Training Activities	Target	Duration (days)	Participants
2002	8	NHC Task Force Orientation	representatives from George Complex	1	25
2002	8	1st Child Health Tas Force	LDHMT/HCs, other related institutions	1	13
2002	9	NHC Election at George	representatives from George Complex	10	478
2002	9	6th CBO Joint Meeting	LDHMT/HCs, CHWs, NPs, NHCs	1	36
2002	9	Training for Follow-up in Environmental Health Activities	GEHC	2	29
2002	9	VIP Latrine Training	GEHC, VIP Latrine beneficiaries	2	25
2002	10	2nd Child Health Task Force	LDHMT/HCs, other related institutions	1	18
2002	10	Training for Basic Health and NHC Orientation (George)	NHC	5	100
2002	10	Training for Planning and Evaluation for CBOs	LDHMT/HC	1	20
2002	11	3rd Child Health Task Force	LDHMT/HCs, other related institutions	1	10
2002	11	Househol Survey (George)	population in N'gombe	20	—
2002	12	4th Child Health Task Force	LDHMT/HCs, other related institutions	1	16
2002	9	7th CBO Joint Meeting	LDHMT/HCs, CHWs, NPs, NHCs	2	71
2002	12	Household Survey (N'gombe)	population in N'gombe	20	—
2002	12	1st Joint Coordination Committee	MoH, LDHMT, HCs	1	46
2002	12	5th Child Health Task Force	LDHMT/HCs, other related institutions	1	14
2002	12	1st Environmental Health Task Force	LDHMT/HCs, other related institutions	1	18
2003	1	2nd Environmental Health Task Force	LDHMT/HCs, other related institutions	1	15
2003	2	6th Child Health Task Force	LDHMT/HCs, other related institutions	1	10
2003	3	7th Child Health Task Force	LDHMT/HCs, other related institutions	1	10
2003	3	3rd Environmental Health Task Force	LDHMT/HCs, other related institutions	1	18
2003	3	8th CBO Joint Meeting	LDHMT/HCs, CHWs, NPs, NHCs	1	42
2002-2003	9-3	Monthly Follow-up Training for CHWs/NPs	CHWs/NPs from 6 project's targeted areas	7 times	
2002-2003	10-3	Working Group for Guideline and Manual of Child Health	LDHMT/HCs, other related institutions	10 times	90
2003	1-3	Working Group for PHAST Manual (EHTF)	LDHMT/HCs, other related institutions	7 times	67
2003	1-3	Working Group for Monitoring and Evaluation (EHTF)	LDHMT/HCs, other related institutions	5 times	32
2003	2-3	Baseline Survey	6 project's targeted areas	30	72

6/13

Track Record of Traininig and Activities

FY (JP) 2003

Y	M	Training Activities	Target	Duration (days)	Participants
2003	4	GMP+ Orientation	LDHMT/HCs	2	69
2003	5	GIS Training	LDHMT	5	5
2003	4-5	Working Group for PHAST Manual (EHTF)	LDHMT/HCs, other related institutions	6 times	45
2003	4-5	Working Group for Monitoring and Evaluation (EHTF)	LDHMT/HCs, other related institutions	8 times	56
2003	5	4th Environmetal Health Task Force	LDHMT/HCs, other related institutions	1	15
2003	6	Training for PHAST Facilitators	LDHMT/HCs	10	13
2003	6	9th CBO Joint MEETING	LDHMT/HCs, CHWs, NPs, NHCs	1	38
2003	7	Training for Community Health Services and activities	HC Staff	15	10
2003	7	Training for CHWs (George)	representatives from George Complex	30	23
2003	7	8th Child Health Task Force	LDHMT/HCs, other related institutions	1	7
2003	8	Strategic Meeting for IEC	LDHMT/HCs	1	17
2003	10	Training for CHWs (N'gombe)	representatives from N'gombe Complex	30	24
2003	8	Workshop for strategic plan for Lusaka District	LDHMT Management staff	1	20
2003	8	Workshop for strategic plan for Lusaka District	LDHMT/HCs staff	1	50
2003	8	2nd Joint Coordination Committee	MoH, LDHMT, HCs	1	50
2003	8	10th CBO Joint Meeting	LDHMT/HCs, CHWs, NPs, NHCs	1	38
2003	9	9th Child Health TASK Force	LDHMT/HCs, other related institutions	1	9
2003	9	Training for NPs (George)	representatives from George Complex	10	27
2003	9	1sl GMP+ Monitoring	LDHMT/HC/CHWs/NPs	6	4
2003	9	Training for NPs (N'gombe)	representatives from N'gombe Complex	10	25
2003	10	Training for CHWs (Kanyama)	representatives from Kanyama Complex	30	23
2003	11	11th CBO Joint Meeting	LDHMT/HCs, CHWs, NPs, NHCs	1	38
2003	11	Training for CHWs (Chawama)	representatives from Chawama Complex	30	24
2003	12	Training for NPs (Kanyama)	representatives from Kanyama Complex	10	27
2003	12	10th Child Health Task Force	LDHMT/HCs, other related institutions	1	10
2003	12	Training for Cholera Control	LDHMT/HCs	1	11
2003	12	Training for Cholera Contact Tracing	HC Staff/Contact Tracing Team	2	26

Track Record of Traininig and Activities

Y	M	Training Activities	Target	Duration (days)	Participants
2003	12	PHAST Workshop (N'gombe)	representatives from N'gombe Complex	7	34
2003	12	Training for Planning of Environmental Health Activities (N'gombe)	N'gombe EHC	1	34
2003	12	Technical Training for Environmental Health Activities (N'gombe)	N'gombe EHC	6	34
2004	1	12th CBO Joint Meeting	LDHMT/HCs, CHWs, NPs, NHCs	1	39
2004	1	11th Child Health Task Force	LDHMT/HCs, other related institutions	1	14
2004	1	1st Environmental Health Stakeholder Meeting	MoH, LDHMT, HCs, Lusaka City Council	1	70
2004	1	2nd GMP+ Monitoring	LDHMT/HC/CHWs/NPs	6	4
2004	1	Training for NPs (Chawama)	representatives from Chawama Complex	10	23
2003-2004	12-2	Door-to-Door Visit for Cholera Prevention	population from 6 project targeted areas	70	–
2004	2	PHAST Workshop (Kanyama)	representatives from Kanyama Complex	7	30
2004	2	Training for Planning of Environmental Health Activities (Kanyama)	Kanyama EHC	1	30
2004	2	Technical Training for Environmental Health Activities (Kanyama)	Kanyama EHC	6	30
2004	2	Cholera Contact Tracing	HC EHTs	14	6
2004	2	Cholera-GIS Epidemiological Survey	EHTs/Contact Tracing Team	40	12
2004	3	1st Child Health Stakeholder Meeting	MoH, LDHMT, HCs, NGOs	1	70
2003-2004	4-3	Monthly Follow-up Training for CHWs/NPs	CHWs/NPs from 6 project's targeted areas	6 times	
2003-2004	10-3	Coordinator Meeting for Community Health	LDHMT/HCs	3 times	30

FY (JP) 2004

Y	M	Training Activities	Target	Duration (days)	Participants
2004	4	13th CBO Joint Meeting	LDHMT/HCs, CHWs, NPs, NHCs	1	29
2004	4	3rd GMP+ Monitoring	LDHMT/HC/CHWs/NPs	6	4
2004	5	Training for Community Health Services	HC Staff	15	16名
2004	5	Training for Hammer Mill (George)	Hammer Mill Committee	2	10
2004	5	Household Survey (Chawama)	population in Chawama	20	–
2004	6	Household Survey (Kanyama)	population in Kanyama	20	–
2004	6	12th Child Health Task Force	LDHMT/HCs, other related institutions	1	11
2004	6	Training for CHWs (Chipata)	representatives from Chipata Complex	30	25名

8/13

Track Record of Trainiig and Activities

Y	M	Training Activities	Target	Duration (days)	Participants
2004	6	Training for Basic Health Care and NHC Orientation (N'gombe)	NHC	3	80
2004	7	Training for CHWs (Mutendere)	representatives from Mutendere Complex	30	23名
2004	7	4th GMP+ Monitoring	LDHMT/HC/CHWs/NPs	6	4
2004	7	Training for CQI	LDHMT/HCs	26 times	150
2004	7	Follow-up Training for Strategi Plan	HC Staff	1	20
2004	7	Training for Management for Community Health Coordinators	Community Health Coordinator	1	34
2004	7	14th CBO Joint Meeting	LDHMT/HCs, CHWs, NPs, NHCs	1	38
2004	7	1st Cholera Task Force	MoH, LDHMT, HCs, Lusaka City Council	1	55
2004	7	Training for NPs (Chipata)	representatives from Chipata Complex	10	24名
2004	7	NHC Election (Mutendere)	representative from Mutendere Complex	1	—
2004	6	Training for Basic Health Care and NHC Orientation (Mutendere)	NHC	3	116
2004	8	Training for NPs (Mutendere)	representative from Mutendere Complex	10	27名
2004	8	Training for Prioritised Action Plan for 2005	LDHMT/HCs	1	100
2004	8	Training for Production of IEC Materials	LDHMT	7	2
2004	9	2nd LDHMT-PHC Project Steering Meeting	LDHMT	1	15
2004	9	3rd Joint Coordination Committee	MoH, LDHMT, HCs	1	55
2004	9	2nd Cholera Task Force	MoH, LDHMT, HCs, Lusaka City Council	1	50
2004	9	Training for Community Drama	Community Volunteers	4	320
2004	9	13Ih Child Health Task Force	LDHMT/HCs, other related institutions	1	14
2004	9	Soya Beans Campaign	NPs	6 times	—
2004	9	15th CBO Joint Meeting	LDHMT/HCs, CHWs, NPs, NHCs	1	38
2004	10	Mid-term Survey	6 project's targeted areas	30	78
2004	10	5th GMP+ Monitoring	LDHMT/HC/CHWs/NPs	6	4
2004	10	Baby Contest	6 project's targeted areas	6 times	—
2004	11	2nd Environmental Health Stakeholder Meeting	MoH, LDHMT, HCs, Lusaka City Council	1	60
2004	11	Training for Cholera Contact Tracing	Community Volunteers	2	30
2004	11	Technical Training for Water Sampling	EHTs	3	7
2004	11	PHAST Workshop (Chawama)	representatives from Chawama Complex	7	30

9/13

Track Record of Traininig and Activities

2004	11	Training for Planning of Environmental Health Activities (Chawama)	Chawama EHC	2	26
2004	12	Training for Door-to-Door Visit for Cholera Prevention	Community Volunteers	12 times	200
2004	12	14th Child Health Task Force	LDHMT/HCs, other related institutions	1	7
2004	12	PHAST Workshop (Mutendere)	representatives from Mutendere Complex	7	30名
2004	12	3rd LDHMT-PHC Project Steering Meeting	LDHMT	1	13
2004	12	CQI Campaign	LDHMT/HCs	1	50
2004	12	Training for Strategi Plan	HC Staff	1	20
2004	7-12	Working Group for Cholera Prevention and Control	MoH, LDHMT, HCs, Lusaka City Council	43 times	298
2004	12	Technical Training for Environmental Health Activities (Chawama)	Chawama EHC	4	16
2005	1－2	Door-to-Door Visit for Cholera Prevention	population from 6 project's targeted areas	70	－
2005	1	Training for Planning of Environmental Health Activities (Mutendere)	Mutendere EHC	2	30
2005	1	16th CBO Joint Meeting	LDHMT/HCs, CHWs, NPs, NHCs	1	54
2005	1	PHAST Workshop (Chipata)	representatives from Chipata Complex	7	30
2005	1	Training for Planning of Environmental Health Activities (Chipata)	Chipata EHC	2	30
2005	1	Cholera Prevention Campaign	6 project's targeted areas	30 times	－
2005	1	Follow-up Training for Strategi Plan	HC Staff	6 times	18
2004	12-1	Study Tour for Environmental Health Activities	EHC (chawama, Chipata, Mulendere)	6	90
2005	2	6th GMP+ Monitoring	LDHMT/HC/CHWs/NPs	6	4
2005	2	Technical Training for Environmental Health Activities (Chipata)	Chipata EHC	6	30
2005	2	Technical Training for Environmental Health Activities (Mulendere)	Mutendere EHC	6	30
2005	2	CQI Activities: 5S Patrol	LDHMT/HCs	1	50
2005	2	4th LDHMT-PHC Project Steering Meeting	LDHMT	1	13
2004-2005	4-3	Environmental Health Monitoring & Evaluation Meeting	LDHMT/EHT	12 times	98
2004-2005	4-3	Monthly Follow-up Training for CHWs/NPs	CHWs and NPs for 6 areas	6 times	
2004-2005	4-3	Coordinator Meeting for Community Health	LDHMT/HCs	7 times	108

List of Project Productions

1. Guidelines and Manuals

Y	M	Item	Description	Form
2003	3	Operational guideline on GMP+ in Lusaka District	guideline of implementing of GMP+ for HC staff and CBO members	A4 sized 33 pages
2003	3	Nutrition Promoters Manual	activity manual for Nutrition Promoters	A4 sized 77 pages
2003	3	Guide for training of Nutrition Promoters	trainer's guide for training of Nutrition Promoters	A4 sized 80 pages
2003	3	Nutrition Counseling Cards	practical guide for Nutrition Promotoers to conduct counselling with community population	A4 sized 12 pieces
2003	5	PHAST Part1: Tool manual	practical guide of PHAST tools with sample visual aids	A4 size 119 pages
2003	5	PHAST Part2: Field Tool	workshop kit of visual aids for PHAST workshop	A4 sized 255 pieces
2003	5	Guideline for Monitoring and evaluation on PHAST	guideline for monitoring and evaluation on community environmental health activities based on PHAST approach, describing with logical frameworks	A4 sized 33 pages
2003	12	Cholera outbreak control measures at community level	briefing of cholera prevention and counter measure for outbreak for community	A4 sized 5 pages
2004	2	The operational guidelines on IMCI community referral system extended from GMP+	guideline for CHWs to carry out community referral	A4 sized 19 pages
2004	4	Lusaka District Health Strategic Plan 2004-2006	3 year strategic plan for Lusaka District for 2004-2006	A4 sized 84 pages
2004	6	PHAST Part1: Tool manual (revised version)	practical guide of PHAST tools with sample visual aids	A4 sized 119 pages
2004	6	PHAST Part2: Field Tool Kits	workshop kit of visual aids for PHAST workshop	A4 sized 248 pages
2004	8	Manual for Continuous Quality Improvement	manual for implementing of CQI activities	A4 sized 20 pages
2004	11	Step by step guide for cholera prevention and control (revised version)	step guide for cholera prevention and control	A4 sized 9 pages
2004	11	Guideline on drainage construction in Peri-urban setting	guideline for CBOs to learn and train how to construct drainage	A4 sized 9 pages
2005	2	Prioritized Action Plan 2005	action plan by each HC based on Strategic Plan of the district, including budget and targets	
2005	2	Lusaka District Operational Guideline for Cholera Prevention and Control	guideline describing approaches and activities for cholera prevention and control	
2005	2	The operational guidelines on Child Health Community Referral (revised version)	guideline describing purposes, strategies and approaches for effective community referral	
2005	3	Manual for Prioritized Action Plan	practical manual for HCs to prepare Prioritised Action Plan	

2. Presentation/Thsis

Y	M	Item	Description	Form
2004	10	19th Japan Association for International Health	Mrs. IGARASHI Kumiko	Presentation
2004	10	19th Japan Association for International Health	Mr. SASAKI Satoshi	Presentation

11/13

2004	10	19th Japan Association for International Health	Dr. MARUYAMA Seishin	Presentation

3. IEC Materials

Y	M	Item	Description	Form
2003	8	Soya beans recipe	recipe to be used for soya beans promotion by Nutrition Promoters	book
2003	8	Marketing for Soya Beans	guide for Nutrition Promoters to sell soya beans	book
2003	9	Kick out Cholera before it kicks you	T-shirts illuminating cholera prevention used for school health activities	T-shirts
2003	10	Uniform for CHWs/NPs	Uniform for CHWs/NPs to wear in their activities	apron
2003	10	Uniform for HC staff	Uniform for HC staff to wear in their daily activities and services	apron
2003	10	GMP+	T-shirts illuminating GMP+	T-shirts
2003	11	Sanitation for all	T-shirts illuminating washing hands, used for Sanitation Week in the district	T-shirts
2003	12	Kick out Cholera before it kicks you	poster illustrating prevention of cholera	poster
2003	12	Kick out Cholera before it kicks you	leaflet describing causes, prevention and care of cholera	leaflet
2003	12	Door to door Health Education material	learning materials for community volunteers to conduct door-to-door health education activities	book
2003	12	Cholera, Cholera, Cholera	song embedding messages for drinking safe water, using clean toilets and nutritious food for cholera prevention	song
2004	4	GMP+/Chipimo Chawana	poster illustrating participation in GMP+	poster
2004	8	Stamp for Environmental Health Committee	Stamp for Environmental Health Committee to acknoeledge cash transactions	stamp
2004	8	Users card for VIP latrine	Users card for VIP latrine	card
2004	9	GMP+ in the community /Take your children for GMP+ every month	leaflet describing GMP+ activities	leaflet
2004	9	Eat soya beans!	T-shirt illuminating soya beans	T-shirts
2004	11	GMP+ for Health Baby	T-shirt illuminating GMP+	T-shirts
2004	11	Have you treated home water	T-shirt illuminating treated water at home	T-shirts
2004	12	Kick out Cholera before it kicks you (revised version)	poster illustrating prevention of cholera	poster
2004	12	Kick out Cholera before it kicks you (revised version)	leaflet describing causes, prevention and care of cholera	leaflet
2005	2	Continuous Quality Improvement (5S)	introducing and implementing of '5S'	poster

Project Expenditures

FY (JP) 2002 (from 15 July 2002 to 31 March 2003)

Applied Excahnge Rate : 1JPY=36.20ZMK

Code	Description	ZMK	JPY
001	Project Administration	184,791,561.17	5,104,739
002	Baseline Survey	16,921,663.82	467,449
101	GMP+	110,171,604.00	3,043,414
102	Environmental Health	52,708,975.00	1,456,049
103	Capacity Development of LDHMT's Community Support	21,670,103.00	598,622
		386,263,906.99	10,670,273.67

FY (JP) 2003

Applied Excahnge Rate : 1JPY=41.39ZMK

Code	Description	ZMK	JPY
001	Project Administration	302,385,066	7,305,752
002	Construction of Office/Conference Room	65,746,864	1,588,472
003	Socio-Economic/Demographi Survey for Community Activities	48,702,783	1,176,680
101	Training of GMP+ Volunteers	133,027,428	3,213,999
102	GMP+ and Monitoring & Evaluation	50,555,021	1,221,431
103	Growth Monitoring and Analysis of Under 2 Children	41,280,144	997,346
201	Production of PHAST Guideline and Promotion of PHAST Workshop	27,430,198	662,725
202	Community Participation for Improvement of Environmental Health	119,697,172	2,891,935
203	Cholera Prevention Campaign	66,526,580	1,607,310
301	Community Referral	6,000,000	144,963
401	Capacity Development of LDHMT's Community Support	17,778,779	429,543
402	Managerial Capacity Development of Community-Based Organisations	31,872,740	770,059
403	Construction of Community Hall (N'gombe HC)	43,978,730	1,062,545
		954,981,505	23,072,759

FY (JP) 2004 (as of 31 January 2005)

Applied Excahnge Rate : 1JPY=43.38ZMK

Code	Description	ZMK	JPY
001	Project Administration	371,119,037	8,555,072
002	Construction of Office/Conference Room	55,172,920	1,271,852
003	Mid-Term Evaluation	24,179,100	557,379
004	Health Information Analysis of Under 2 Children	17,891,960	412,447
101	Training of GMP+ Volunteers	108,548,500	2,502,271
102	GMP+	44,741,940	1,031,396
103	Monitoring & Evaluation on GMP+	5,121,300	118,057
201	Environmental Health Activities Based on PHAST Approach	101,800,495	2,346,715
202	Cholera Prevention Campaign	90,404,241	2,084,007
301	Capacity Improvement of Child Health Case Management and Community Referral	86,148,282	1,985,899
401	Capacity Development of LDHMT's Community Support	16,086,360	370,824
402	Managerial Capacity Development of Community-Based Organisations	30,011,046	691,818
403	Production of IEC Multimedia Materials	49,356,858	1,137,779
		1,000,582,040	23,065,515

Annex 4

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

March 18, 2005

Activities	Expected Results	Schedule									Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
		2005			2006			2007							
		2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q					
1.1 Develop GMP+ package at the level of the District	Developed and standardized GMP+ package at the level of the District														
1.1.a Form Child Health Task Force and have regular meetings at District level	Formed CHFT and held regular meeting at District level	X	X	X	X	X	X	X	X	X	MPD	MCH Coordinator District Nutritionist		Meeting cost	Coordinate with stakeholders
1.1.b Develop guidelines on and training materials for GMP+	Developed Guidelines and training materials for GMP+										MPD	MCH Coordinator District Nutritionist		Meeting cost	
1.1.c Revise the guidelines on and training materials for GMP+	Revised Guidelines and training materials for GMP+	X					X				MPD	MCH Coordinator District Nutritionist	Guidelines and training materials	Meeting cost	Cost sharing with DHMT and JICA starts year 2006
1.2 Conduct capacity building	HC staff and CBOs equipped knowledge and skills to conduct GMP+ activities														
1.2.a Conduct ToT for Health Centres staff in Community Health	Trained 60 HC staff as trainers	X				X					MPD	MCH Coordinator District Nutritionists	Guidelines and training materials	Training cost	Cost sharing with DHMT and JICA and include year 2004 and
1.2.b Analyse demand for CHWs & NPs with stakeholders	Identified number of CHWs and NPs required	X				X					Sister in-charge MCH in-charge	CHCs		Meeting cost	Coordinate with stakeholders
1.2.c Train community members as CHWs and NPs	Trained 600 community members as CHW/NP		X				X				MCH in-charge Sister in-charge	CHCs	Guidelines and training materials	Training cost	
1.2.d Orient CHWs and NPs to an adopted approach of GMP+	Oriented 600 CHWs and NPs on GMP+	X	X			X	X				MCH in-charge	CHCs	Guidelines	Meeting cost	Cost sharing with DHMT and JICA
1.2.e Conduct refresher workshop for CHWs and NPs	Equipped knowledge and skills in community health for CHWs and NPs	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	MCH in-charge	CHCs		Workshop cost	Cost sharing with DHMT and JICA starts year 2004
1.2.f Strengthen capacity of CHWs/NPs in nutrition counselling	Equipped 600 CHWs/NPs on nutrition counselling	X				X				X	Nutritionists	CHCs	Counselling cards	Training cost	
1.3 Implement under 2 registration	Under 2 registration implemented														
1.3.a Conduct an orientation on under 2 registration for CHWs & NPs	Orientated 600 CHWs and NPs on under 2 registration		X	X							MCH in-charge	CHCs	Under 2 register Guidelines	Orientation cost	
1.3.b Conduct household survey	Conducted 6 household surveys		X	X							Nutritionist CHCs	CHWs NPs	HH survey forms Under 2 register Maps	Survey cost	

Activities	Expected Results	Schedule									Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
		2005			2006			2007							
		2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q					
1.3.c Register under 2 children	Registered under 2 children	←	—	—	—	—	—	—	—	→	Nutritionist	CHWs NPs	Under 2 register		Allowances from Buscket Fund
1.4 Conduct GMP+ activities	Conducted monthly GMP+ activities	←	—	—	—	—	—	—	—	→	MCH in-charge Nutritionist	HC staff CHWs NPs	GMP+ supply package	Outreach allowance	Cost covers 100% by DHMT
1.5 Conduct home visit to follow up GMP+ defaulters and under weight children	Followed up GMP+ defaulters and under weight children	←	—	—	—	—	—	—	—	→	Nutritionist	CBOs	Under 2 register Follow-up register		Allowances from Community Basket Fund
1.6 Promote GMP+ to the community	GMP+ activities promoted to the community														
1.6.a Conduct sensitisation for GMP+	Sensitised community on GMP+	←	—	—	—	—	—	—	—	→	MCH in Charge Nutritionist	CHWs NPs NHC	Megaphone Batteries		
1.6.b Conduct baby show competitions in the community	Conducted 80 baby show competitions		X				X				MCH in Charge Nutritionist CHCs	CHWs NPs NHC	Check sheets Prizes		Coordinate with stakeholders
1.6.c Conduct soya recipe competitions in the community	Conducted 80 Soya recipe competitions		X				X				Nutritionist CHCs	NPs	Soya recipe Utensils Prizes		Coordinate with stakeholders
1.7 Establish monitoring and evaluation system for GMP+ activities	Effective M&E system for GMP+ established														
1.7.a Train LDHMT and health centre staff in monitoring and evaluation	Trained 60 DHMT and HC staff on M&E			X				X			MPD	MCH Coordinator District Nutritionist	Guidlines	Training cost	DHMT / JICA
1.7.b Conduct monitoring & evaluation according to the guidelines	Conducted 15 monitoring sessions according to the guidelines	X	X	X	X	X	X	X	X	X	MPD	MCH Coordinator District Nutritionist	Monitoring tool		Cost sharing with DHMT and JICA (Integrate to performance assessments)
1.7.c Hold monitoring and evaluation meeting at each level of the District, HC and CBOs	Held M&E meetings at 1) District level 2) HC/CBOs level	XXX	XXX	XXX X	XXX	XXX	XXX	XXX X	XXX	XXX	1) MCH Coordinator District Nutritionist 2) MCH in-charge CHCs	CHCs CHWs and NPs	Statistics Data collection tool	Meeting cost	Cost sharing with DHMT and JICA
1.8 Promote child health key behaviours through IEC activities	Caretakers practice child health key behaviours														
1.8.a Develop IEC strategies and materials	Developed IEC strategies and materials	X									District IEC officer Assistant	CHCs CBOs	JICA computers	Material production cost	Cost sharing with DHMT, JICA and CARE
1.8.b Conduct IEC orientation for CBOs	Oriented 600 CBOs on IEC		X								District IEC officer Assistant	CHCs	IEC materials	Orientation cost	
1.8.c Conduct IEC activities	Conducted various IEC activities	←	—	—	—	—	—	—	—	→	CHCs	CBOs	IEC materials Drugs, T-shirts, Chitenge		

Activities	Expected Results	Schedule									Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
		2005			2006			2007							
		2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q					
1.9 Share information and experience on GMP+	Information and experiences on GMP+ shared														
1.9.a Hold joint meeting for CHWs and NPs	Held 20 Joint meetings	X	X	X	X	X	X	X	X	X	MCH Coordinator District Nutritionist	CHC CBOs		Meeting cost	Cost sharing with DHMT and JICA starts 2003 (50%)
1.9.b Conduct field trips for CHWs & NPs within and out of Lusaka	Conducted field trip for CHWs and NPs		X				X				MCH Coordinator District Nutritionist	CHC CBOs		Allowances	
1.9.c Initiate coordination meeting with stake- holders & donors	Held 4 Child health stakeholder meetings				X				X		MPD	Child health task force members		Meeting cost	

OUTPUT 2: Community-based environmental health activities are enhanced

Activities	Expected Results	Schedule									Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
		2005			2006				2007						
		2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q					
2.1 Strengthen capacity of GEHC to ensure sustainability	Developed sustainable model for E/H activities										EHT for George	GEHC members		Meeting cost	
2.2 Develop PHAST guidelines and training manual including visual aids	Guidelines and manuals										EHO	EHTs		Meeting, Printing cost	Visual aids suitable for peri-urban setting
2.3 Conduct Capacity building	Improved capacity of HC staff and community														
2.3.a Conduct ToT for HC staff on PHAST approach	15 (3x5) HC staff trained in PHAST ToT										EHE	Trainers	Manual	Training cost	
2.3.b Hold PHAST workshop and identify priority needs on environmental health	PHAST workshop in each catchments area Identification & prioritisation of needs										EHTs	Trained CHCs	Manual Visual aids	Workshop cost	
2.3.c Conduct orientation on the concept of PHAST approach for LDHMT staff	Improved knowledge		X								EHE	EHE	Manual Visual aids	Workshop cost	
2.4 Support CBOs to plan and implement their action plans to address priority needs in line with child health	Implementation of planned activities	→	→	→	→	→	→	→	→	→	EHO	EHTs Committee	Action plan	Material cost for pilot project	
2.5 Conduct monitoring and evaluation following guidelines	Monitored & evaluated activities	X	X	X	X	X	X	X	X	X	EHE	EHTs	Monitoring guide	Meeting cost	
2.6 Develop and carry out IEC activities concerning environmental health and personal hygiene in communities	Developed IEC materials & Conducted IEC activities	→	→	→	→	→	→	→	→	→					
2.6.a Develop and revise IEC materials on hygiene and sanitation practices at households level	Developed and revised IEC materials										EHE	District IEC officer EHTs	IEC materials		
2.6.b Train CBOs on door to door health education	Trained CBOs			X				X			EHTs	EHTs	Training material	Training cost	
2.6.c Conduct door to door health education	Improved knowledge of community people			X	X			X	X		EHTs	CBOs	IEC material	Printing cost	

Activities	Expected Results	Schedule									Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
		2005			2006				2007						
		2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q					
2.7 Support cholera control and prevention programme in the community	Conducted Cholera prevention and control activities before and during rainy season in each compound														
2.7.a Form the task force on cholera prevention and control at level of District and conduct meetings	Task force on cholera formed	→	→	→	→	→	→	→	→	→	Director of LDHMT	Members of the Taskforce	Stationery	Stationery	Coordinate with stakeholders
2.7.c Develop and revise the guidelines on cholera prevention and control in Lusaka District	Guidelines	→									MPD	Working group members	Guidelines	Printing cost	
2.7.d Conduct refresher training for HC staff	Trained HC staff		X				X				MPD	HC staff	Training material	Training cost	
2.7.e Hold cholera sensitisation meetings with stakeholders at LDHMT and HC level	Meetings held at LDHMT and HC level	X	X	X	X	X	X	X	X	X	MPD EHTs	EPPC members	Refreshment	Meeting cost	
2.7.f Train CBOs on cholera contact tracing	36 trained CBOs/ training (6/HC)			X				X			EHTs	EHTs	Guidelines Sprayers Protective clothes	Training cost	
2.7.f Conduct awareness campaign for cholera prevention	Increased awareness		X	X	X		X	X	X		EHTs	EHTs CBOs	IEC materials, megaphone, battery Prizes Refreshment		
2.8 Hold annual meetings for environmental health with stakeholders	Held annual meeting		X				X				MPD	EHE EHTs		Meeting cost	

OUTPUT 3: Community referral services for under 5 children are enhanced

Activities	Expected Results	Schedule									Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
		2005			2006			2007							
		2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q					
3.1 **Develop and review effective system on child health community referral in Lusaka District**	Revised Case Identification Manual														
3.1.a Form the working group for the child health community referral	Working group formed										Group chairperson	Clinical officers		Meeting cost	
3.1.b Develop and revise the guidelines on child health community referral	Developed and revised guidelines			X				X			Group chairperson	Clinical officers	Guidelines	Meeting cost Printing cost	
3.1.c Orient HC staff for child health community referral system	Oriented 400 HC staff on community referral										Clinical care expert	Selected coordinators per centre (2)	Guidelines	Orientation cost	
3.1.d Train CHWs and case identification and referral	Trained 300 CHWs in community referral					X					HC in-charge	Selected coordinators per centre (2	Guidelines	Training cost	
3.1.e Introduce first aid kit to CHWs	Introduced and maintained First aid kit	←								→	HC in-charge	Selected coordinators per centre (2)	First aid kit Kits supplied to deserving CHWs (passed test)	Consumables	Consumables of first aid kit will be replaced by LDHMT based on the HC action plan
3.1.f Conduct IEC activities to sensitise caretakers on general danger signs and community referral	Conducted various IEC activities	←								→	DHMT IEC Unit	Coordinators, CHWs, CBOs	IEC materials	Material production cost	I
3.2 **Develop and revise effective operation system on nutrition clinic**															
3.2.a Form the working group for nutrition clinic at the level of District	Formed Working Group and hold regular meetings	X									District Nutritionist	Nutritionists in HCs	Stationery	Allowances	Coordinatation with UTH, NFNC and WFD formed in Apr 2005
3.2.b Develop the guidelines on nutrition clinic	Developed guidelines	X				X					District Nutritionist	Nutritionists in HCs	Stationery	Allowance Printing	
3.2.c Train HC staff in management of malnourished children	Trained Selected HC staff (OPD, MCH, IPD)	X									District Nutritionist	Nutritionists in HCs	Stationery Manuals	Allowances	Methodology of training to be discussed
3.2.d Train NPs in management of malnourished children	Trained 300 NPs	X									HC nutritionists	Coordinators	Stationary Manuals	Manual for community	
3.2.e Conduct monitoring and evaluation for nutrition clinic	Conducted Monitoring and evaluation meetings		X	X	X	X	X	X	X	X	District Nutritionist	HC Nutritionists	Stationary	Allowances	

Activities	Expected Results	Schedule									Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
		2005			2006			2007							
		2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q					
3.3 Construct and utilize health post as community referral points															
3.3.a Conduct feasibility study on health post to serve as community referral points	Feasibility Study Report										DDH MPD	Consultant	Transport	Consultancy fee	Approval of CBoH required
3.3.b Construct health posts based on the feasibility study	Constructed 1 Health Post										MPD Sister in Charge EHT	Contractors		Initial costs	
3.3.c Pilot project of these health facilities	Pilot facilities in operation										MPD Sister in charge CHCs	Sister in charge CBOs	Medical Equipment, furniture, drugs, stationary	Operational cost	HC personnel has to be posted
3.3.d Conduct monitoring and evaluation on the pilot project	Conducted monitoring and evaluation	X	X	X	X	X	X	X	X	X	MPD	Sister in charge CHCs	Stationary	Allowances	
3.3.e Replicate facilities in other areas	3 HPs to be built (Kanyama, Chawama, Mtendere)				X						DDH MPD	Sister in Charge EHT	Medical equipment, furniture, drugs, stationary	Construction costs	Evaluation has to approve expansion 1st quarter 2006

OUTPUT 4: Planning and financing capacity of LDHMT and health centres in support for community-based health activities is strengthened

Activities	Expected Results	Schedule									Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
		2005			2006			2007							
		2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q					
4.1 Facilitate to formulate Lusaka District Health Strategic Plan 4.2	Documents completed										DDH	MPD			
4.1.a Form the task force and working groups	Task Force and Working Groups formed				↔						MPD	MPD	Stationery Refreshment	Printing cost, Stationery, miscellaneous	
4.1.b Facilitate to formulate Lusaka District Health Strategic Plan every three year	Strategic Plan formulated					↔		↔			DDH	MPD			
4.3 Facilitate to formulate Prioritized Action Plan	Prioritised Action Plan formulated										MPD	MPD			
4.2.a Form the working groups and task force	Working Groups and TASK Force formed										MPD	MPD	Stationery, transport refund, refreshment		
4.2.b Facilitate to formulate Prioritized Action Plan of six health centres every year	Prioritised Action Plan for six HCs formulated	↔	↔			↔	↔				MPD	WG	Stationery, transport refund, refreshment		
4.2.c Facilitate to formulate Prioritized Action Plan of the District every year	District Prioritised Action Plan formulated	↔	↔			↔	↔				MPD	WG	Stationery, refreshment		
4.2.d Produce a manual for Prioritized Action Plan	Manual for Prioritised Action Plan produced										MPD	WG	Stationery		
4.2.e Conduct monitoring and evaluation quarterly at all levels	Monitoring and Evaluation done	↔	↔	↔	↔	↔	↔	↔	↔	↔	MPD	WG / HC staff	Stationery Transport Refreshment		
4.2.f Hold monitoring and evaluation meeting quarterly	Monitoring and Evaluation meetings held	↔	↔	↔	↔	↔	↔	↔	↔	↔	MPD	WG / HC staff	Stationery Transport Refreshment		
4.3 Establish the health information sharing system	Systems identified										MPD	WG	Stationery Transport Refreshment		
4.3.a Produce Lusaka District Health Data Book of baseline information	Lusaka District Health Data Book produced										MPD	WG	Stationery	Printing cost	
4.3.b Produce Lusaka District Health Data Bulletin annually	Lusaka District Health Bulletin produced annually				↔				↔		MPD	WG	Stationery Transport Refreshment	Printing cost	
4.3.c Hold a forum for health information sharing annually	Forum held					↔				↔	DDH	WG	Stationery Transport Refreshment	Printing cost	

Activities	Expected Results	Schedule									Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
		2005			2006			2007							
		2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q					
4.4 Conduct financial analysis and resource allocation for LDHMT	Financial analysis & resource allocation done										MA	WG	Stationery Transport Refreshment	Printing cost	
4.4.a Form the task force	Task Force formed	◄►									MA	MA	Stationery Transport Refreshment	Printing cost	
4.4.b Produce financial reports annually	Financial reports produced				◄►				◄►		MA	WG	Stationery Transport Refreshment	Printing cost	
4.4.c Facilitate to allocate LDHMT budget to community-based health activities according to financial report	Budget allocated to community-based health activities				◄►				◄►		MPD	WG	Stationery Transport Refreshment	Printing cost	
4.5 Improve operational efficiency through Continuous Quality Improvement	Service produced improved										DDH	WG	Stationery Transport Refreshment	Printing cost	
4.5.a Organize 5S committee	Committee organised										MA	WG	Stationery Transport Refreshment	Printing cost	
4.5.b Produce CQI manual	Manual produced										DDH	DDH	Stationery Transport Refreshment	Printing cost	
4.5.c Conduct CQI refresher for LDHMT and health centres	Refresher courses in CQI conducted	◄►	◄►			◄►	◄►			◄►	DDH	WG	Stationery Transport Refreshment	Printing cost	
4.5.d Conduct 5S activities at all levels	5S activities conducted	◄►	◄►	◄►	◄►	◄►	◄►	◄►	◄►	◄►	DDH	WG	Stationery Transport Refreshment	Printing cost	
4.5.e Hold 5S award festival annually	Incentives given to deserving HC staff			◄►				◄►			DDH	WG	Stationery Transport Refreshment	Printing cost	

OUTPUT 5: Management capacity of CBOs to ensure sustainability of community based health activities is strengthened

Activities	Expected Results	2005			2006			2007			Person in Charge	Implementer	Materials & Equipment	Cost	Remarks
		2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q					
5.1 Establish an effective mechanism to strengthen NHC activities	Capacity of NHC in managing community activities is strengthened														
5.1.a Compile operational guidelines to standardize NHC activities	Operational guidelines		X								MPD	Working group (to be established)		Meeting cost Printing	
5.1.b Support election of NHC	Newly elected NHC members		Election schedule to be confirmed								HC in charge	HC community health coordinator	Refreshment Megaphone, batteries		
5.1.c Conduct NHC orientation and training in basic health care package	Improved knowledge and skill of NHC members		Election schedule to be confirmed								HC in charge	HC community health coordinator	Training materials for basic health care package	Orientation cost	
5.1.d Hold CBOs joint meeting at HC level	Held CBOs joint meeting	X	X	X	X	X	X	X	X	X	NHC	NHC		Meeting cost	
5.2 Establish community basket fund system	Community basket fund established in six health centres														
5.2.a Form community basket fund committee at level of HC and CBOs and hold regular meetings	Held monthly meeting	X	X	X	X	X	X	X	X	X	Sister In charge Committee chairperson	Committee members		Meeting cost	
5.2.b Introduce and sustain income generating ventures	Sustained Income generating ventures	→	→	→	→	→	→	→	→	→	CHCs	Committee members	Various materials	Various materials	
5.2.c Conduct training for community health coordinators & CBOs in management skills	Trained community health coordinators & CBOs	X	X								LDHMT CHCs	LDHMT CHCs	Training materials,	Training cost	
5.2.d Hold joint meetings in community basket fund	Quarterly joint meetings held		X		X		X		X	X	Community health coordinator	Community health coordinator		Meeting cost	

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
CBO	= Community-based Organisation
NHC	= Neighbourhood Health Committee
GEHC	= George Environmental Health Committee
PHAST	= Participatory Hygiene and Sanitation Transformation

実施プロセス

<table>
<tr><th>評価項目</th><th>調査項目</th><th>検証手段</th><th>結果</th></tr>
<tr><td>1. 実施計画･実績の比較</td><td></td><td>-プロジェクト報告書
-C/P・専門家インタビュー</td><td>プロジェクトはフェーズ 1 からの継続であり、最初からスムーズな実施が可能となった。しかし、さまざまな理由による実施の遅れもあった（詳細は、「効率性」参照）。</td></tr>
<tr><td>2. 技術移転方法の適切性</td><td></td><td>-プロジェクト報告書
- C/P･専門家インタビュー</td><td>プロジェクトは、2 つの技術移転方法を用いた。まず、マネジメント、コミュニティをベースとした活動の知識・スキルの技術移転は、タスクフォース、ワーキンググループの下、ガイドライン、マニュアル、戦略計画の作成を通じて行われた。このため、実際の過程を通じて、必要な知識・スキルを学ぶことができた。また、カウンターパート職員の能力は、さまざまな研修プログラムにより、直接強化された。カウンターパート職員は、より高い能力を得ただけでなく、オーナーシップとパートナーシップの意識を持つようになった。</td></tr>
<tr><td>3. プロジェクト管理システム</td><td></td><td>-プロジェクト報告書
-C/P･専門家インタビュー</td><td>プロジェクト管理メカニズムは、中央政府、市、ヘルスセンター、コミュニティの各レベルに構築された。

[合同調整委員会]
合同調整委員会は、保健省、中央保健総局、ルサカ州保健局、国家食糧・栄養委員会、ルサカ市役所、LDHMT・ヘルスセンター職員などから構成される。委員会会議は、毎年、ステークホルダー会議と同時に開催される。これまで、2002 年 12 月、2003 年 8 月、2004 年 9 月に開催されている。

<table>
<tr><th>年月</th><th>内容</th><th>参加者</th></tr>
<tr><td>2002/12</td><td>プロジェクト概要・活動計画</td><td>46</td></tr>
<tr><td>2003/8</td><td>プロジェクト進捗、PDM 改定</td><td>50</td></tr>
<tr><td>2004/9</td><td>プロジェクト進捗・成果達成状況</td><td>55</td></tr>
</table>

[スティアリング委員会]
スティアリング委員会は、LDHMT とプロジェクトの間で四半期ごとに開催されている。

[タスクフォース会議]
タスクフォースは、ガイドライン・マニュアル作成のためだけでなく、各課題の戦略策定機構としても機能している（各タスクフォース会議の詳細は、「効率性」を参照）。</td></tr>
<tr><td>4. 実施機関・C/P のプロジェクトに対する認識</td><td></td><td>-C/P インタビュー
-保健省、中央保健総局インタビュー</td><td>プロジェクトは、フェーズ II であり、すでに、LDHMT（実施機関）と職員によく認識されている。</td></tr>
</table>

5. C/P の配置		-プロジェクト報告書 - C/P・専門家インタビュー	LDHMT から 10 人がカウンターパートとして任命されている。ヘルスセンターは、1 ヶ所あたり 6～8 人プロジェクトに関与している。
6. 実施プロセスにおける貢献・阻害要因		-C/P・専門家インタビュー	[プロジェクトの準備活動] プロジェクトは、フェーズ I（1997～2002）から継続している。2 人の日本人専門家が、プロジェクト開始前の数ヶ月の間に綿密な準備をし、フェーズ II は最初からスムーズな実施が可能となった。