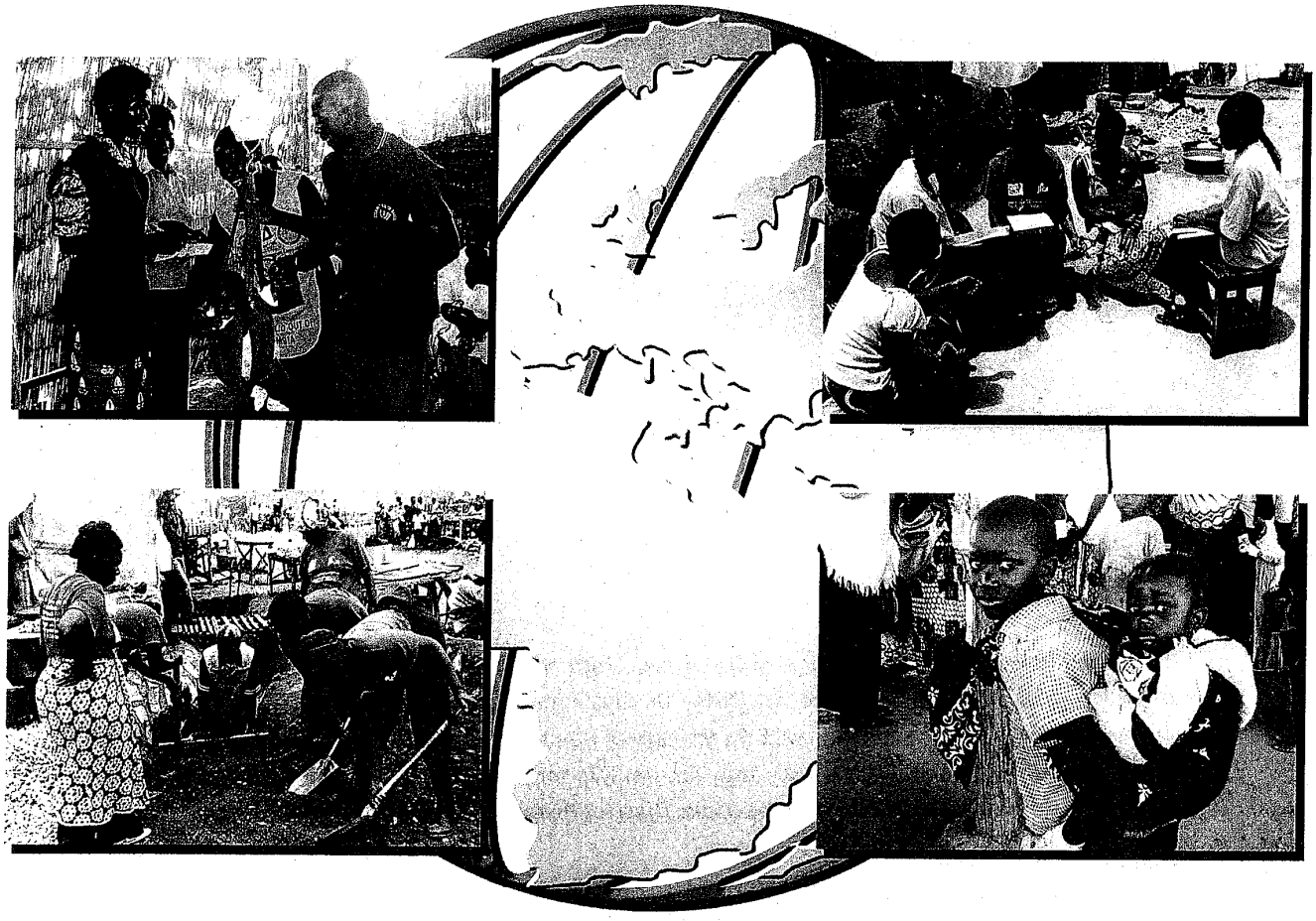
Ministry of Health

GUIDELINES

FOR

INTEGRATED COMMUNITY-BASED CHILD HEALTH PACKAGE



JUNE, 2007

MINISTRY OF HEALTH, ZAMBIA
JAPAN INTERNATIONAL COOPERATION AGENCY

The ***Guidelines for Integrated Community-based Child Health Package*** were edited by Dr. Victor MUKONKA, Dr. Penelope KALESHA, Dr. Bushimbwa TAMBATAMBA, Dr. Mpundu Chikoya MAKASA, Dr. Clara MBWILI-MULEYA, Ministry of Health of Zambia and Dr. YAMAMOTO Kayoko, Ms. OHNO Nobuko, Mr FUJINO Yasuyuki, Ms. KIM Yorin and Dr. SASAKI Satoshi, JICA experts, based on the experiences of the ***Lusaka District Primary Health Care Project*** that was implemented from 1997 to 2007.

Those who contributed to the production of the attached guidelines and manuals are acknowledged in each of the items.

June, 2007

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FOREWORD

The Lusaka District Health Management Team (LDHMT) of the Ministry of Health, the Government of the Republic of Zambia, in close collaboration with the Japan International Cooperation Agency (JICA) has implemented the Primary Health Care Project in the unplanned settlements in Lusaka since 1997, and it has been found that the project has produced tangible results in improvement of health status of under five children in those areas.

Although the Project is scheduled to end in July 2007, the Ministry of Health intends to continue to implement the activities it introduced and to scale up such activities to include other areas in the country. To this end, it is important that the Project approaches and its outcomes are put together and systematically organized, so that it could be expected that the possible necessary cost in any terms for scalingup the Project model are minimized, and that the essence of the Project can be effectively and efficiently communicated to and shared with future target areas.

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Dr. Simon Miti
Permanent Secretary
Ministry of Health
Republic of Zambia

June 2007

Dr. Miti addressing the Joint Coordinating Committee meeting in 2005

Signing the minutes of the meeting between the Government of Zambia and Japan
(left: Prof. Umenai, Leader of Project Supporting Committee)

MESSAGE FROM THE DIRECTOR OF THE LDHMT AND THE RESIDENT REPRESENTATIVE OF JICA ZAMBIA

The Guidelines for Integrated Community-based Child Health Package summarise the key concepts of the Lusaka District Primary Health Care Project implemented by the Lusaka District Health Management Team (LDHMT) in close collaboration with the Japan International Cooperation Agency (JICA)for a duration of ten years from 1997 to 2007. It has been recognised that the Project approach and methodology contributed to the improvement of the health status of under-5 children in the target areas. Although this Project focused especially on Lusaka's unplanned settlements, it can be expected that through appropriate modification and adjustment based on the specific conditions and circumstances of different settings, the essence of this approach and methodology can also be effectively applied in various contexts.

Dr. Bushimbwa TAMBATAMBA
District Director of Health, Lusaka

Seven years have passed since The Millennium Development Goals were established, among which reducing child mortality is emphasised as one of the most important issues to be addressed. According to The Millennium Development Goals Report 2006, however, Goal 4 - reducing the mortality rate among children under-5 by two thirds - is still far from being achieved.

The Government of Zambia has recognised child health as one of its national health priorities. Community-based Integrated Management of Childhood Illness (C-IMCI) was introduced in 1998 and the National Strategic Plan 2006-2010 on Child Health in the Community was developed in 2005, in order to improve the health status of children under 5 years of age. To ensure the attainment of MDG 4 in Zambia, several community-based child health activities have been incorporated into district action plans and are currently being implemented.

Mr. INUI Eiji
Resident Representative JICA - Zambia

Child health has been one of the top priorities for the LDHMT, and the Project is proud to have realised considerable improvements in this field, as seen through the changes in the key indicators used in this Project. This has reinforced our belief that a community-based approach to child health is a crucial element in realising advances in this regard. This especially rings true considering the shortage of health staff that Lusaka District, and the country as a whole are facing.

In line with, as well as in response to, global trends in health and Zambian national health policy and strategy, JICA has been working together with the Government of Zambia, and its Ministry of Health, in the field of child health. It is regarded as one of the top priority areas of Japan's Official Development Assistance (ODA) strategies. The Primary Health Care Project is part of these strategies. It should be emphasised that this Project also successfully reflected JICA's focus on a 'Field-Oriented Approach' and on the enhancement of 'Human Security'.

In terms of a 'Field-Oriented Approach', the Project made community participation one of the key concepts of its approach, recognising the importance of a community's role in identifying and analysing people's real needs, and solving their problems. The Project has also provided learning opportunities for people, especially caretakers, to obtain practical health care and management knowledge for their children, as well as for community leaders to help people to take the initiative in preventing infectious diseases.

It has also been recognised that the Project, through its approach, has reflected and manifested JICA's perspective on 'Human Security', in terms of protecting people at a grassroots level from threats to their well-being, as well as empowering people to cope with them.

It is our hope that the lessons learnt from the Project will be utilised effectively and efficiently with a view to improving child health status throughout the country, and it is for this reason that these guidelines are produced.

We believe these guidelines shall be practically useful for all the stakeholders working in the field of child health, especially governmental institutions and their partner organisations that implement community activities in urban areas in Zambia as well as in other Sub-Saharan African countries.

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Dr. Bushimbwa TAMBATAMBA
Director of Health
LDHMT

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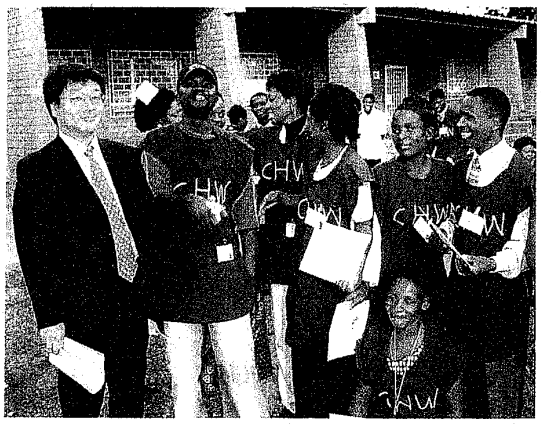
Mr. INUI Eiji
Resident Representative
JICA Zambia Office



Mr. Inui congratulating community volunteers who have completed 6 weeks of training

Dr. Tambatamba chairing a preparation meeting with WHO, UNICEF, HSSP and JICA for a Regional Conference

ACKNOWLEDGMENTS

The Lusaka District Primary Health Care Project will soon end its 10-year implementation period, having achieved considerable improvements and impacts in the six target areas. We the authors of this publication would first and foremost like to cordially express our appreciation to the community health volunteers, without whose dedicated and tireless efforts these achievements would not have been possible. We would also like to express our appreciation to the staff at both the LDHMT and Health Centre levels for their efforts in realising the successful implementation of these activities. Lastly, we would like to express our sincere gratitude to all other institutions and individuals who, working together with us, have helped to make this Project a success.

List of Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
BHCP	Basic Health Care Package
CBGMP	Community-based Growth Monitoring Promotion
CBO	Community-based Organisation
CBoH	Central Board of Health
CHC	Community Health Coordinator
CHP	Child Health Promoter
CHW	Community Health Worker
C-IMCI	Community-based Integrated Management of Childhood Illness
CO	Clinical Officer
CSO	Central Statistical Office
DHS	Demographic and Health Survey
DPT	Diphtheria, Pertussis and Tetanus
EHC	Environmental Health Committee
EHO	Environmental Health Officer
EHT	Environmental Health Technologist
FAMS	Financial Administration Management System
GDP	Growth Domestic Product
GMP+	Growth Monitoring Programme Plus
HC	Health Centre
HCC	Health Centre Committee
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSSP	Health Services and Systems Program
IEC	Information, Education and Communication
IGVs	Income Generating Ventures
IMCI	Integrated Management of Childhood Illness
IPF	Indicative Planning Figures
IRS	Indoor Residual Spraying
JICA	Japan International Cooperation Agency
LDHMT	Lusaka District Health Management Team
MCH	Maternal and Child Health
MoH	Ministry of Health
MUAC	Mid-Upper Arm Circumference
NGO	Non-governmental Organisation
NHC	Neighbourhood Health Committee
NP	Nutrition Promoter
OPV	Oral Polio Vaccine
PAI	Performance Assessment for Improvement
PAP	Prioritised Action Plan
PDM	Project Design Matrix
PHAST	Participatory Hygiene and Sanitation Transformation
PHC	Primary Health Care
PHO	Provincial Health Office
PMTCT	Prevention of Mother to Child Transmission of HIV/AIDS
TB	Tuberculosis
TOT	Training of Trainers
UNICEF	United Nations Children's Emergency Fund
USAID	United States Agency for International Development
UTH	University Teaching Hospital
VIP	Ventilated Improved Pit
WHO	World Health Organisation

INTRODUCTION

Since 1997, The Ministry of Health of Zambia has implemented the Lusaka District Primary Health Care (PHC) Project in close collaboration with the Japan International Cooperation Agency (JICA) in the Chawama, Chipata, George, Kanyama, Mtendere and Ng'ombe areas, which are known as unplanned settlements, in Lusaka. The PHC Project Phase I, which was implemented only in George from 1997, found that the Growth Monitoring Programme Plus (GMP+) and Participatory Hygiene and Sanitation Transformation (PHAST) methodology were appropriate and effective ways of improving the knowledge and behaviour of people as well as the situation of environmental health in the Project area of George. Based on these results, Phase II of the Project was officially launched in 2002 to expand these approaches to five other areas.

Through Phase II, the Project has developed and implemented an "Integrated Community-based Child Health Package", which integrates GMP+, PHAST and a Community Basket Fund System to secure supplemental resources for community activities as well as for community volunteers through income-generating activities. This integrated approach has shown a great impact on the improvement of the health status of children in the six Project areas. In addition, it was obvious that community interventions like this Project have the potential to provide equitable coverage by reaching families with children who may not adequately utilise the services of the health system, as they are socially marginalised in a setting like that in unplanned settlements.

As the Project comes to an end in July 2007, it is vital that the experiences and lessons of the Project be summarised and that the essence of the implementation methods be systematically documented in the form of guidelines so as to effectively share them with all the governmental health institutions and their partner organisations in Zambia. Accordingly, these "Guidelines for Integrated Community-based Child Health Package" have been developed by the Ministry of Health, the Project and stakeholders.

The guidelines consist of two parts. Part 1 describes the essential points of the Project impacts, approaches, and methodologies used in the Project, while Part 2 introduces a collection of practical guidelines and manuals, as well as IEC materials and tools which were developed and utilised over the course of the Project, including a clear explanation of their contents, aims, and how to use them.

In Part 1, the first section outlines the background in Zambia and Lusaka to which the Project has been shaped to fit, including socio-economic status and health situation. The second section is a Project overview that describes the outline and structure of the Project and its major components of activities. In the third section, the notable impacts brought about by the Project activities are outlined, as measured by comparisons of baseline and terminal surveys (both qualitative and quantitative). The fourth section discusses the key approaches behind the Project's successes. These key approaches are summarised in 8 points including lessons learnt that are also thought to be applicable to other similar types of health projects in and beyond Zambia. Finally, the fifth section briefly introduces the packaged activities developed through the course of this Project, which are categorised into five parts: community-based child health, community-based environmental health, health administrative management, financial sustainability, and institutionalisation of CBOs. Part 2, following the packages introduced in the fifth section of Part 1, offers a variety of practical guidelines and manuals, as well as IEC materials and tools which are classified according to the above packaged activities. Each product is introduced with an explanation aiming to identify "for what" and "by whom" it should be utilised.

As a whole, the guidelines are intended to enable those concerned to fully understand how to organise and implement the Integrated Community-based Child Health Package in their own areas.

Part 1
Achievements and Approaches

I. BACKGROUND

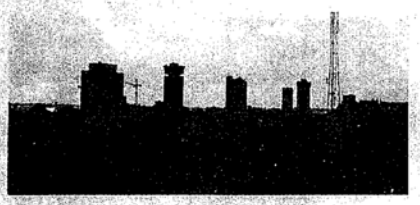
1 Socio-economic Status in Lusaka

[1] This estimate is projected using data from the CSO 2000 and HMIS, LDHMT.

As of 2006, Lusaka District had an estimated population of 1,676,322,[1] which is more than 10% of the national population of Zambia. Lusaka Province is one of the most urbanised in Zambia and has a population density of 63.5 person/km2 in 2000 that has doubled from 31.6 in 1980 (CSO, 2003). Lusaka District has seen an even more conspicuous urbanisation with a population density of 3,013.1 in 2000 (CSO, 2003). This increase includes many people who have migrated from outside and have started living in unplanned settlements (otherwise known as compounds). The rapid increase of population has served to complicate the social situation in Lusaka, and has resulted in a great burden on the system of social services, most notably health and education.

Lusaka, being the capital city of the country, is the largest centre of international and inter-city trade, and of commercial investments such as shops and small to medium scale enterprises. Although the real GDP growth rate in recent years has been approaching 5%, poverty continues to affect the majority of households in Lusaka. The poverty headcount ratio was 57% in Lusaka as a province in 2003, while the national poverty headcount ratio was 67% (CSO, 2004a). Employment opportunities in the formal sector are limited, resulting in most people being involved in various forms of informal self-employment.

Figure 1.1 Map of Zambia



Lusaka City

Victoria Falls

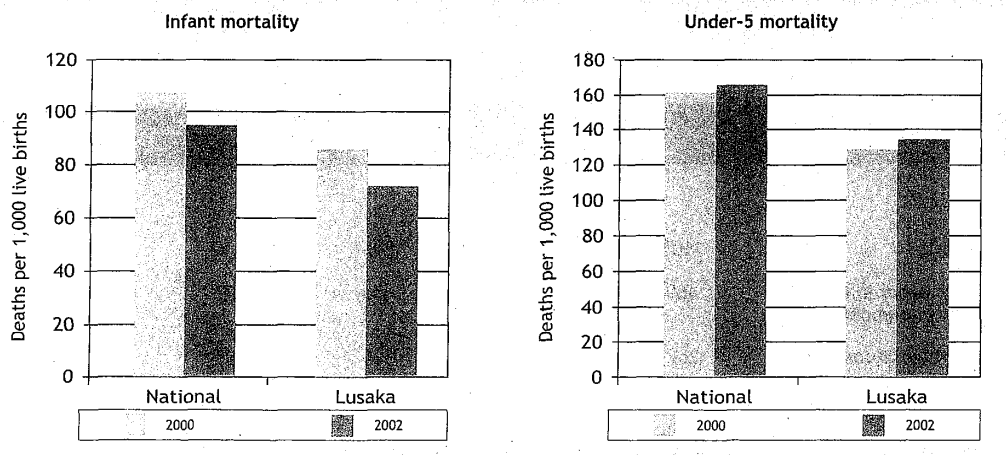
The average literacy rate for male adults in Lusaka as a province is 87.6%, while for females it is 78.8%. These rates are slightly higher for the District, at 90.1% for male adults and 81.3% for female adults. In both cases, the literacy rates in Lusaka are much higher than those representing the country as a whole: 76.6% and 58.3% respectively in 2000 (CSO, 2003).

2 Health Indicators in Lusaka and Zambia

The infant mortality rate in Lusaka Province was 70 per 1,000 live births and 95 in Zambia as a whole in 2002, which improved from 88 and 110 respectively in 2000. On the other hand, the under-5 mortality rate was 137 per 1000 live births in Lusaka and 168 in Zambia in 2002, which deteriorated from 126 and 162 respectively in 2000 (CSO/CBoH/Macro, 2003). The percentage of fully immunized children was 84.5% in Lusaka Province and 73.5% in Zambia in 2003, compared to 71% and 76% in 2000 (MoH, HMIS). The prevalence of underweight children (moderate and severe) was 12% in Lusaka and 21% in Zambia in 2003, which slightly improved from 13% and 23% in 2000 (MoH, HMIS).

The maternal mortality rate in Zambia was 729 per 100,000 live births in 2002 (CSO/CBoH/Macro, 2003), which deteriorated from 649 in 1996 (CSO/CBoH/Macro, 1997). The total fertility rate in Lusaka Province was 4.3 and 5.9 in Zambia in 2002 (CSO/CBoH/Macro, 2003), which decreased from 6.0 and 6.7 respectively in 1990 (CSO, 2003). The proportion of births attended by skilled health personnel was 74.9% in Lusaka Province and 43.4% in Zambia in 2004 (CSO/CBoH/Macro, 2003), which was 74.1% and 46.5% in 1996 (CSO/CBoH/Macro, 1997). It must be noted, however, that there are some discrepancies in the figures between DHS (Demographic and Health Survey) data and HMIS (Health Management Information System) data. Life expectancy was 55 in Lusaka Province and 52 in Zambia in 1980, which deteriorated to 50 and 47 in 1990 and slightly improved to 54 and 50 in 2000 respectively (CSO, 2003).

Figure 1.2 Infant and Under-5 Mortality Rate of Lusaka Province and Zambia



(CSO/CBoH/Macro, Zambia Demographic and Health Survey (ZDHS): 2001-2002, 2003)

Generally speaking, most of the health indicators in Lusaka as a province are much better than those in Zambia as a whole. However, for HIV the prevalence rate was much higher in Lusaka Province (19.5%) and in Lusaka District (21.1%) than in Zambia (13.5%) in 2006 even though it improved from 22.3% in Lusaka Province, 24.1% in Lusaka District and 15.8% in Zambia in 2000 (CSO, 2004b).

The proportion of households with access to safe drinking water in Lusaka as a province was 95% and 54% in Zambia in 2003 (CSO, 2004a), which improved from 88% and 47% respectively in 1996. The proportion of households with access to sanitary means of excreta disposal in Lusaka was 97% and 77% in Zambia in 2003 (CSO, 2004a), which also improved from 33% and 18% respectively in 1996 (CSO, 1997). Most unplanned areas mainly use pit latrines rather than Ventilated Improved Pit (VIP) latrines, which are the more appropriate type in areas where it is not possible to install a sewer system or septic tank.

3 Disease Pattern of Under-5 Children in Lusaka District

As mentioned earlier, under-5 mortality in Zambia is still high. Although estimates show that urban areas have a lower rate of under-5 mortality than rural areas, the health conditions for these children remain vulnerable. The incidence of the four major diseases continues to be much higher in the under-5 age group compared with the over-5 age group. In addition, it can be observed that the Lusaka District has a higher incidence rate of diarrhoea (non-bloody) and pneumonia compared to the national average.

4 General Structures of the MOH and LDHMT

Since 1992, the Government of Zambia has been implementing Health Sector Reforms, which aimed at improving the health status of all Zambians through ensuring equity of access to cost effective, quality health services as close to the family as possible. Under the National Health Services Act of 1995, the Central Board of Health (CBoH) and health management boards were created in order to address shortcomings in the then existing organisational structure.

Table 1.1 Incidence of the Major Causes of Morbidity in 2000 (Cases per 1,000 population)

Area	National		Lusaka Province		Lusaka District
Age group	Under-5	Over-5	Under-5	Over-5	Under-5
Disease					
Malaria	1108	197	806	190	544.7
Respiratory Infection (Non-pneumonia)	469	87	440	87	330.1
Diarrhoea Non-Bloody	258	31	335	59	281.6
Respiratory Infection (Pneumonia)	132	21	185	32	166.9

(Annual Health Statistical Bulletin 2005, MoH and LDHMT Action Plan 2007-2009)

However, notwithstanding efforts made to define the roles and functions of the MoH and those of the CBoH, a certain degree of duplication of roles and functions was apparent. In addition, the National Decentralization Policy of 2003 brought about the transfer of many functions and activities previously undertaken by the central level to the district and provincial levels.

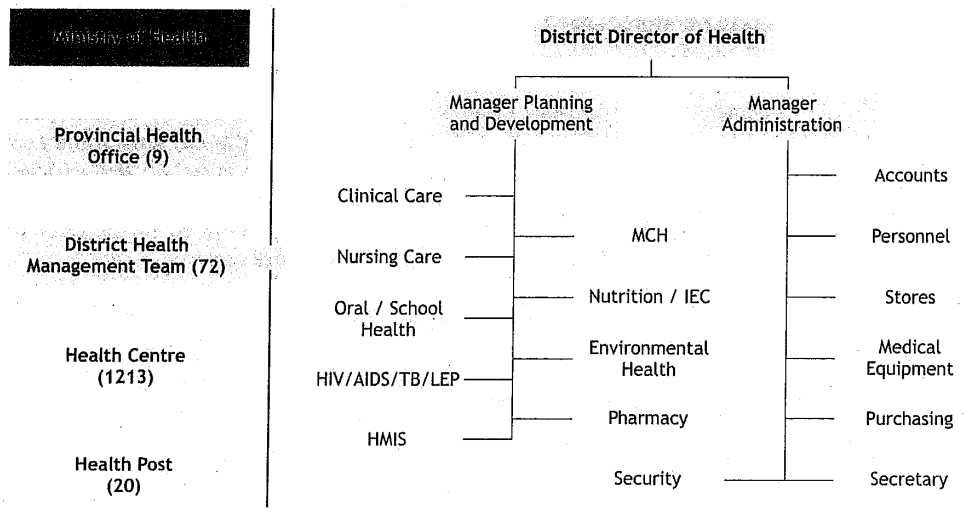
Against this background, the National Health Service Act of 1995 was repealed leading to the dissolution of the CBoH together with the hospital and district health management boards in 2006. The MoH and CBoH merged and the management and control of all public health facilities and services came to directly fall under the MoH through the Provincial Health Office. The core functions of the MoH are (1) health services delivery, (2) policy and planning and (3) human resources, administration and logistical support.

The LDHMT consists of Administration, and Planning and Development components, under which several technical departments are functioning, including Maternal and Child Health (MCH), Environmental Health, HMIS, Pharmacy, Tuberculosis, HIV/AIDS, Oral Health, School Health, Nutrition, and Information, Education and Communication (IEC).

The LDHMT is currently supervising 25 Health Centres (HCs), 3 sub-centres and 3 Health Posts. The number of HCs offering maternity services is 9. MCH as well as Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT) services are available at all the facilities except for the Airport Clinic.

Several factors have adversely affected the performance of the health sector in Lusaka. One of the biggest constraints to the provision of quality health services is a critical shortage of health personnel. As of August 2006, comparisons between the number of personnel thought to be necessary for the provision of health services, and the number of personnel deployed, revealed a shortage of 339 health personnel, of which 150 were midwives. Other factors include generally inadequate levels of funding for services, and the poor state of facilities and equipment.

Figure 1.3 Organisational Charts of the MoH and LDHMT



II. PROJECT OVERVIEW

Unplanned settlements were created due to large-scale and rapid migration from rural areas that outpaced urban planning. People moving to these areas usually in search of employment opportunities often had no choice but to live in horrendous conditions, sometimes surrounded by piles of abandoned trash and daily household wastes and using simple holes in the mud as toilets. This was largely because public social services such as education and health infrastructure development, including electricity, roads, water supply and sanitation could not catch up with the rapid population growth of the District. Such an overburdened urban environment with its high population density gave rise to mass outbreaks of cholera during the rainy seasons; was related to the spread of HIV/AIDS and other STIs (Sexually-Transmitted Infections); and contributed to a rapid increase in tuberculosis and measles cases.

As part of the strategy to improve this situation, George was selected as a site for the construction of a water provision system funded by a Japanese grant aid project (1994-1998). Moreover, various types of technical cooperation, including fostering community leaders, empowering the water management committee and improving its facilities, and training committee members in water and sanitation, were provided in collaboration with CARE, an international NGO. George was selected as the site for Phase I of the Lusaka District Primary Health Care Project (hereafter referred to as "the Project").

1 Community-based Integrated Approach

The purpose of the Project (Phase I) was to establish a community-based model of primary health care in an urban setting, integrating community-based activities by community volunteers, school health activities, health education and promotion activities, and strengthening of the referral system and laboratory capacity.

Throughout its 5-year implementation period, the Project significantly achieved the reduction of the incidence rate of the major childhood diseases and the improvement of health and sanitation conditions. Among the above Project interventions, two were found especially effective and efficient, namely the Growth Monitoring Programme Plus (GMP+) and a set of community-based environmental health activities based on Participatory Hygiene and Sanitation Transformation (PHAST) method.

The Government of Zambia recognised and realised these achievements and requested the expansion of the Project to other similar areas in Lusaka. Accordingly, from July 2002, five Health Centre catchment areas - Chawama, Kanyama, Ng'ombe, Chipata, Mtendere - were included in Phase II of the

Project, which puts particular emphasis upon the improvement of the health conditions of under-5 children through an integrated approach of GMP+ and environmental health activities.

These two activities are comprised of several components. GMP+ includes growth monitoring, health education, nutrition counselling and immunisation, while community-based environmental health activities include latrine construction, implementation of a garbage collection service, and door-to-door health education. These activities are recognised to be corresponding to the national health policies. The Government of Zambia addresses the importance of improving household and community practices (Community-based IMCI) to reduce the infant and child mortality in the country in its National Strategic Plan on Child Health drafted in 2005 (MoH, 2005a). This Strategic Plan identifies 16 Key Family Practices classified under the areas of 'Growth Promotion and Development', 'Disease Prevention', 'Home Management' and 'Care Seeking and Compliance to Treatment and Advice', which cover all of the various community-based practices promoted by the Project. At the same time, PHAST has been identified as a prioritised activity for environmental health by the Government of Zambia in line with its National Health Strategy (MoH, 2005b).

Figure 2.2 shows the Community-based Integrated Approach adopted by the Project. GMP+ and PHAST activities cover the recommended Key Family Practices. The Project particularly focuses on prevention, early detection of the symptoms of diseases and care seeking - the most important interventions in communities before people become seriously in need of treatment. Overall, the Project approach is contributing to the reduction of morbidity and mortality caused by the most common diseases and to the improvement of the health status of under-5 children.

Nutrition counselling by a Nutrition Promoter at a GMP+ site

Supplementation of Vitamin A by a volunteer at a GMP+ site

Social mapping practice at a PHAST workshop

Figure 2.1 Lusaka and Project Site Map

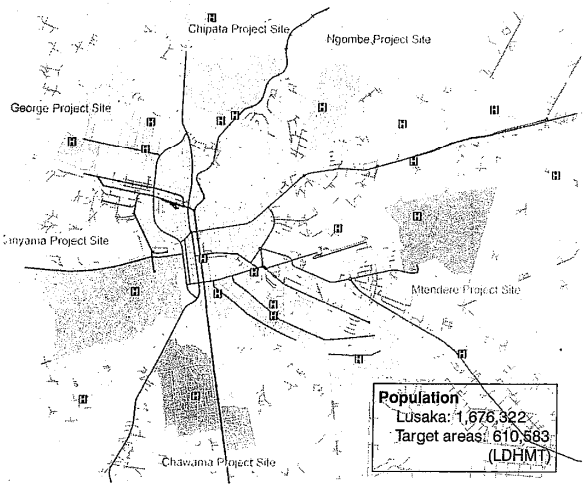
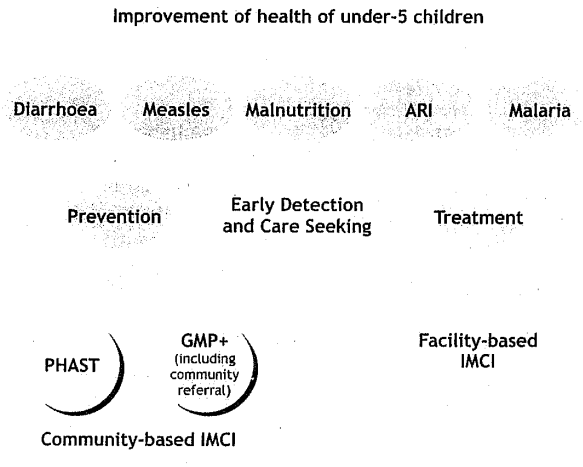


Figure 2.2 Community-based Integrated Approach



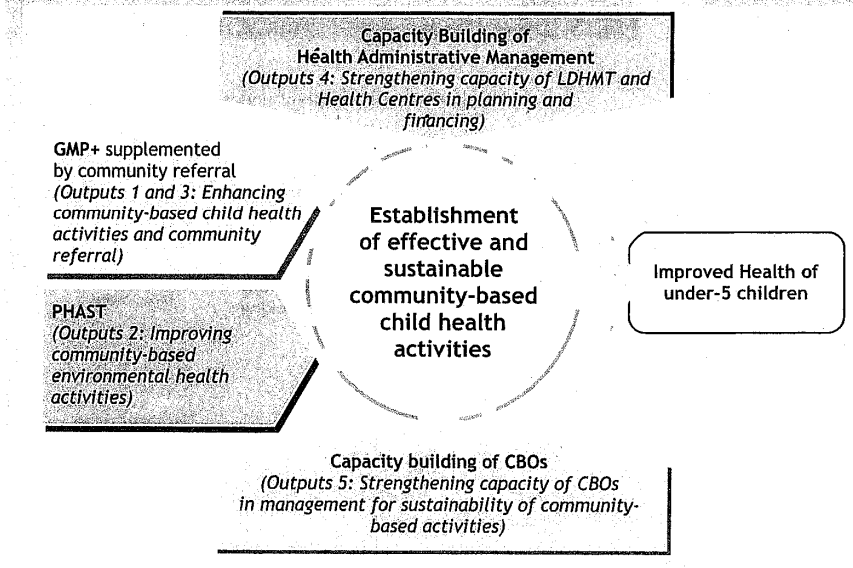
2 Project Purpose and Outputs

The purpose of the Project (Phase II) is to improve the health status of under-5 children through the establishment of effective and sustainable community-based health activities in selected Health Centre catchment areas. In order to achieve the Project purpose, the Project is expected to produce the following five outputs:

(1) Community-based child growth promotion (CBCGP) is enhanced
(2) Community-based environmental health activities are improved
(3) Community referral services for under-5 children are enhanced
(4) The planning and financing capacity of the LDHMT and Health Centres in support of community-based health activities is strengthened
(5) The management capacity of CBOs is strengthened to ensure the sustainability of community-based health activities

As mentioned above, two community-based health activities, namely (1) GMP+ and (2) environmental health activities based on PHAST, are the key components of the Project. GMP+ activities are supported and supplemented by (3) community referral services for under-5 children. These community activities (1), (2) and (3) are reinforced by (4) capacity building of the LDHMT and Health Centres which supervise and support community activities, and (5) capacity building of CBOs (Community-based Organisations) that are committed to field activities. Therefore, it is designed in a way that these activities are to be jointly coordinated and implemented by both the government and the community.

Figure 2.3 Diagram of Project Purpose and Outputs




Environmental Health Committee members shielding a pit of a VIP latrine


A health volunteer receiving a caretaker and her child for GMP+

3 Project Activities and Achievements of Each Output

Output 1:

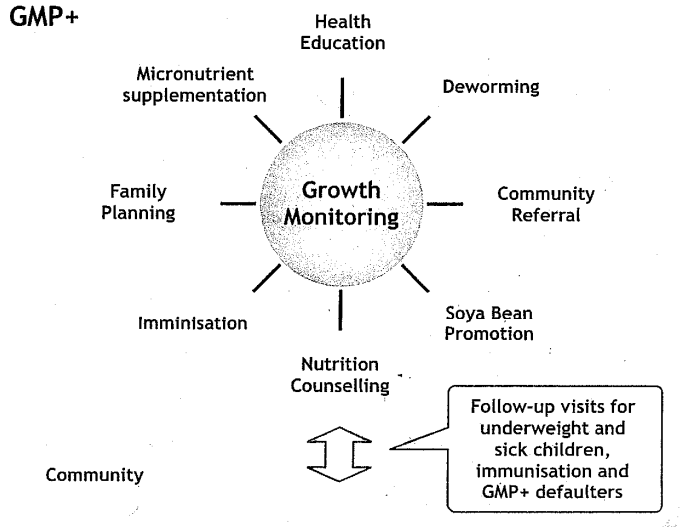
Community-based child growth promotion (CBCGP) is enhanced

CBCGP has been enhanced in all of the six Health Centre catchment areas targeted by the Project through the introduction of GMP+. The programme includes weighing of children as an entry point to health education, nutrition counselling, soya bean promotion, community referral, immunisation, family planning, micronutrient supplementation and deworming.

GMP+ is now a well-established mechanism to facilitate access to basic health care services for under-5 children in the Project target areas. Using a 6-week training programme for Community Health Worker (CHWs) and a 2-week programme for Nutrition Promoters (NPs), the Project mobilised and trained a total of 242 CHWs and 252 NPs to date. These volunteers have become the backbone of the GMP+ activities - in light of the ongoing shortage of Health Centre staff, these volunteers are now able to implement these sessions themselves, with the supervision of Community Health Coordinators (CHCs: HC staff that have completed a 5-day training course who work closely with the community). As a result, more GMP+ sessions can be held, with sessions now being organised at the pre-identified GMP+ sites usually once a month at all of the units in the HC catchment areas. As of 2006, there were 78 GMP+ session points in the catchment areas with increasing attendances by the caretakers.

Figure 2.4 GMP+ Components

Activities at GMP+ sites



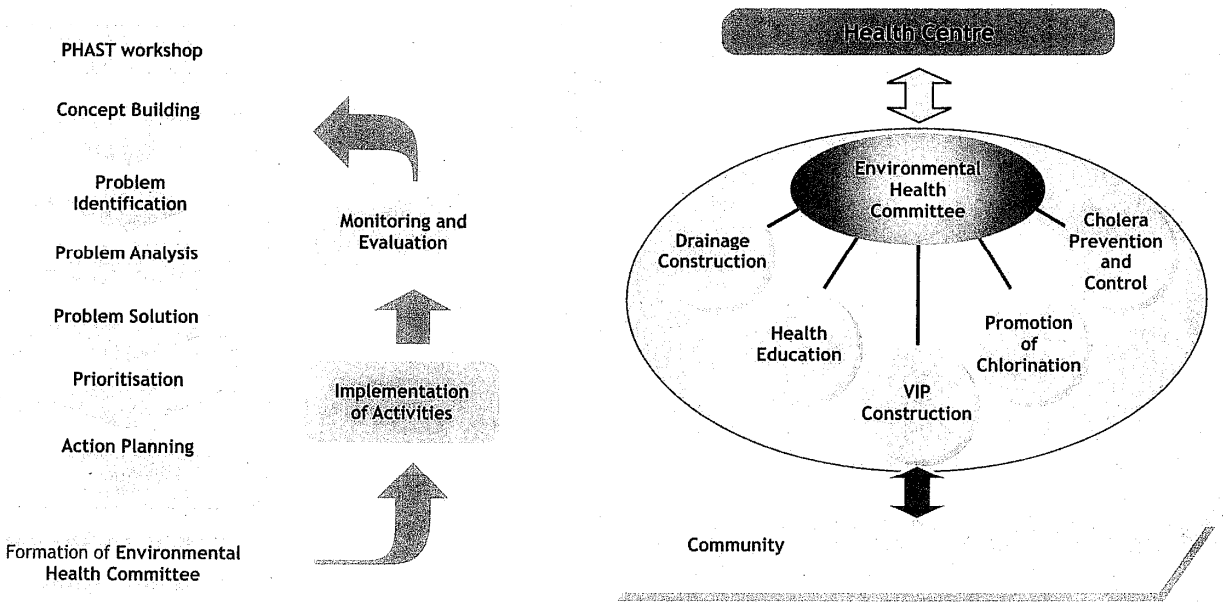
In order to monitor the quality aspect of the GMP+ sessions, Performance Assessment for Improvement (PAI) is carried out on a quarterly basis, which is recorded jointly by the LDHMT and the Health Centre staff for self-assessment. Furthermore, various meetings and working groups are organised at different levels to strengthen the communication between the field and the management, partly for monitoring purposes. For example, regular refresher workshops for community volunteers are facilitated by CHCs at the HC level; regular CHC meetings take place at the District level; and annual meetings for the Child Health Technical Working Group, Task Force and Child Health Stakeholders are held to address specific technical issues relating to child health and to share information with other stakeholders.

Output 2:

Community-based environmental health activities are improved

The core approach introduced in this Output was the promotion of Participatory Hygiene and Sanitation Transformation (PHAST). PHAST is an approach designed to promote hygienic behaviour, improvements in sanitation, and community management of sanitary facilities using specifically developed visual tools and other participatory techniques. Through PHAST and various community-based sensitization activities, the Project succeeded in improving the perceptions and practices towards hygiene and sanitation among the community members and equipped them with the skills and tools to prevent diarrhoeal diseases including cholera.

Figure 2.5 PHAST Implementation Flow and Environmental Health Committee



At the centre of all environmental health activities in each of the catchment areas is the Environmental Health Committee (EHC), comprising of community volunteers trained in PHAST methodology. To date, the Project has trained 316 community members at PHAST workshops. The workshops were implemented for a period of 11 days including field exercises by Environmental Health Officers and Environmental Health Technologists (EHO/EHTs) and other CHCs, at each of the Health Centres.

Door-to-door health education by community volunteers

Based on the priority activities identified during the PHAST workshops, the EHC members have implemented the construction of hygiene and sanitation facilities such as Ventilated Improved Pit (VIP) latrines and drainage, provided services such as solid waste management and vector control, conducted door-to-door community sensitisation, and carried out health inspection and other educational activities. To date, 156 VIPs, and a total of 1,800 metres of drainage were constructed. Door-to-door sensitisation was conducted to 47,842 households in the six target areas from December 2005 to April 2006 (6,287 in George, 11,956 in Kanyama, 15,100 in Chawama, 7,140 in Chipata, 9,486 in Ng'ombe, 4,160 in Mtendere), and 68,726 households from November 2006 to April 2007 (5,759 in George, 24,582 in Kanyama, 10,380 in Chawama, 11,520 in Chipata, 6,539 in Ng'ombe, 9,940 in Mtendere).

Volunteers laying flat stones for drainage

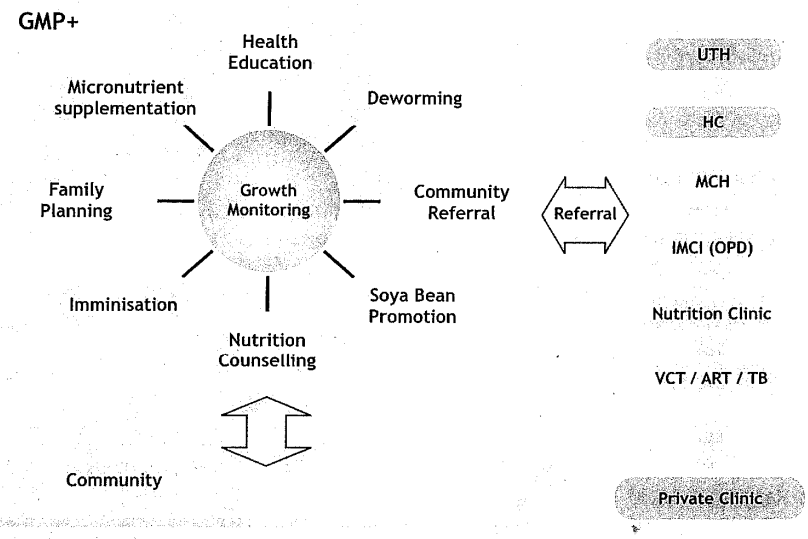
Output 3:

Community referral services for under-5 children are enhanced

In all the six target areas, the community's capacity for case identification and referral of under-5 children has been developed. Community referral systems are currently functioning, although with some degree of variance.

It was observed that case identification by the CHWs has improved significantly, and that both caretakers as well as Health Centre staff trust the CHWs in their capacities. It was also noticed that the caretakers are now bringing the children to the Health Centres through community referrals in a timelier manner before the conditions become critical, and are now able to identify the danger signs themselves and take the initiative to bring their children to the Health Centres. Health education activities conducted at the GMP+ sessions with effective IEC materials also contributed to this attitude change.

Figure 2.6 Community Referral Flow of GMP+



CHW measuring the temperatures of a sick child

Kanyama Health Post

Nutrition Clinics are now operating on a regular basis, and children with mild to severe malnutrition without complications are being referred from the communities or from other departments within the Health Centres. Malnourished children discharged from the University Teaching Hospital are also followed up at the clinics.

A Health Post was inaugurated in the highly populated Kanyama catchment area in July 2005, and since then has been providing much needed health services through the function of a monthly GMP+, outpatient department and Nutrition Clinic in an area where people have difficulties accessing the Health Centre.

Output 4:

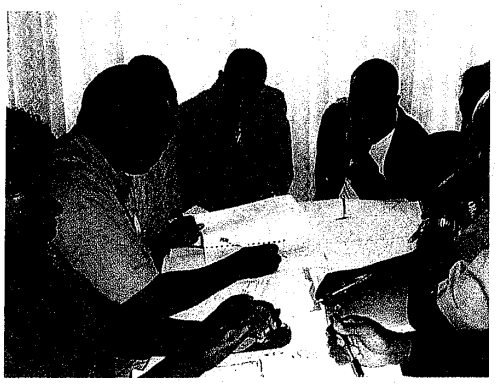
Planning and financing capacity of LDHMT and Health Centres in support for community-based health activities is strengthened

The planning capacity of the LDHMT and Health Centres in support of community-based health activities has been strengthened through the introduction and implementation of evidence-based planning methodology and strategic thinking. Nevertheless with regards to the financing capacity, much is dependent on the availability of resources through the budget - an issue that remains a major constraint.

In 2004, the LDHMT completed a Health Strategic Plan for 2004 to 2006 for the first time at the District level. The draft for the Health strategic Plan for 2007 to 2011 is currently being finalised at the District level. The Prioritised Action Plan (PAP) exercise has been well embraced not just by the Health Centres in the Project target areas, but also by 19 other Health Centres under the LDHMT.

In an effort to address the widening gap between planning and implementation, the Financial Working Group was established in 2005 to conduct a comprehensive analysis (Annual Financial Reports) of the resource outlay available to the LDHMT. Through its discussions, areas were highlighted in which further capacity development was required, particularly in financial management and reporting. Several training sessions to improve these areas were conducted for both the LDHMT and the Health Centres (FAMS/HMIS orientation, cashier training, etc.).

Information sharing between and among the LDHMT and the 25 Health Centres was improved to a certain degree with the publication and circulation of the Lusaka District Health Data Book 1998-2004, Lusaka District Health Data Bulletin 2005, and the regular publication of the Monthly Information Bulletin.



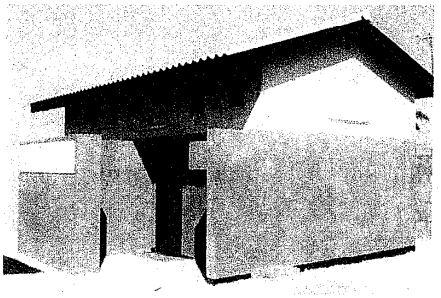
Discussions at a LDHMT planning workshop

Output 5:

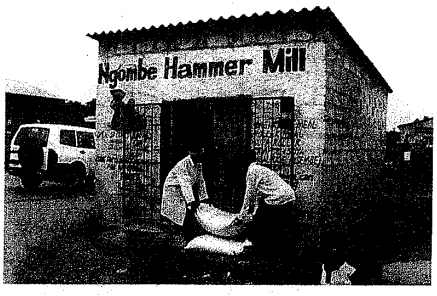
Management capacity of CBOs to ensure sustainability of community-based health activities is strengthened

The strengthening of the management capacity of CBOs with a view to ensuring the sustainability of community-based health activities has been achieved to a reasonable degree. Each of the CBOs in the six Project target areas has now established among themselves a Community Basket Fund Committee (COBAF), which is responsible for the operational and financial management of the Income Generation Ventures (IGVs) under the supervision and control of the CHCs. The Committee members received management training facilitated by CHCs, and are enhancing their capacities on the job through the implementation of the ventures.

These ventures are intended to generate financial resources to fund incentives for the community volunteers participating in GMP+ and environmental health activities, so that they are able to sustain the community-based health activities by generating income themselves. To date, nine ventures have been launched and seven are currently making profits.



Chawama fee-paying toilet block constructed as an IGV



Hammer mill business as an IGV in Ng'ombe

NHC orientation in Chipata

Besides the above efforts, the Project also worked to strengthen the coordination among the CBOs at a local level through the capacity building of the Neighbourhood Health Committees (NHCs) at each Health Centre. NHCs are CBOs that provide linkage between communities and their Health Centres. NHCs are mandated with the pivotal roles of mobilising the communities, and of formulating annual community-based action plans. NHCs were originally established as part of the Health Sector Reforms in 1994, but in many areas (especially urban) they had become inactive.

The Project succeeded in reviving the NHCs in the six target areas, through support to elections of their members, provision of capacity development opportunities, and organisation of the first Annual General Meeting for all NHCs in Lusaka District in 2006. The NHC members are now often seen accompanying the community volunteers in implementing GMP+ or PHAST activities, and take part in the Community Basket Fund Committee. Furthermore, CBO joint meetings are now being held under the leadership of the NHC for enhanced coordination at the community level.

Figure 2.7 Community Basket Fund System

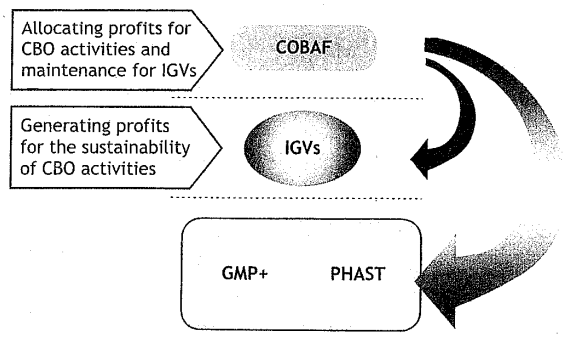


Figure 2.8 Structure for Coordination of CBOs