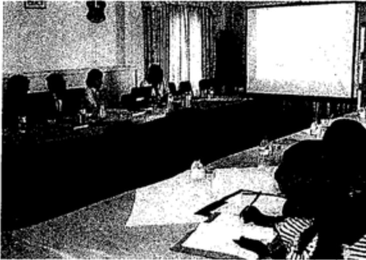
V. PROJECT OPERATION AND ACTIVITY PACKAGE

Based on the experiences and lessons of the 10-year intervention from 1997-2007, the essential activities for realising tangible improvements in the health situation of under-5 children have been consolidated in an integrated package of community-based child health activities. The package is designed to enable the MoH to smoothly and efficiently continue the activities and to scale them up effectively to areas in need. In addition, considerable attention has been paid to ensure the sustainability of the activities, and hence measures aimed at the long-term effectiveness of such activities have also been incorporated into the package.

The package is composed of five essential activities: community-based child health activities, community-based environmental health activities, health administrative management, financial suitability of community-based activities, and institutionalisation of networking among CBOs. This section briefly describes the components of each activity, including the required materials and resources as well as guidelines and manuals.

1 Minimum Package of Community-based Child Health Activities

Community-based child health activities are aimed at reducing the major diseases of under-5 children, such as measles, malnutrition and acute respiratory infections, by promoting recommended key family practices in communities and strengthening the community referral system, including case identification. In this Project, GMP+ has been the key approach employed to integrate all the necessary health services for under-5 children in communities. The activities in GMP+ are designed to promote the key family practices recommended for communities in the National Strategic Plan on Child Health as earlier mentioned in the Project Overview. For the operation of GMP+, the following steps were established for the minimum package: (1) decision making and coordination on community-based child health activities, (2) capacity building for the implementation of GMP+, (3) implementation of GMP+, and (4) putting in place a monitoring and evaluation system for GMP+.


Discussion to develop guidelines at a Child Health Task Force Meeting

A. *Decision making and coordination on community-based child health activities*

For the implementation of GMP+, it is necessary for the District and Health Centre to prioritise child health and strategise regarding GMP+ related activities in the action plans. The focal persons in the planning and budgeting of GMP+ including community referral aspects are the MCH coordinator, Nutritionist and Clinical Care experts at the DHO level, and the MCH nurses, Nutritionist and CO at the Health Centre level. Based on their action plans, the focal persons conduct and monitor the activities in accordance with the budget following a management cycle.

In the Project, a Child Health Technical Working Group was organised at the LDHMT. The purpose of the Group is to analyse the child health indicators and the progress as a District, and then to plan for quarterly Child Health Task Force meetings, which enable the sharing of information regarding community child health activities with other stakeholders operating under LDHMT catchment areas. The LDHMT is tasked with the role of coordinating the child health activities by stakeholders in order to ensure that limited resources are used effectively (see, for example, the ***Operational Guidelines on Nutrition Clinic in Lusaka District***). As such, while the Technical Working Group meetings are primarily internal, the Task Force meetings involve external parties. Discussions at these two meetings should be reflected in decision making in the child health policy of the LDHMT and it is expected that the results can further be used for advocacy purposes to improve child health throughout Zambia.

A session of TOT

B. *Capacity building for the implementation of GMP+*

A participant demonstrating ORS making in a session of CHW training

(1) *Training of Trainers (TOT) in Community Health at the Health Centre level*
The main training courses relevant to GMP+ activities are TOT in community health and training for CHWs and NPs. TOT in community health is for Health Centre staff who wish to work closely with the communities they serve, and this particular Project focuses on MCH nurses, Nutritionists, COs and EHO/EHTs. The selection for trainees is done by the MCH Coordinator and Nutritionist at the District Health Office. The training takes 6 days including a GMP+ site visit. Those Health Centre staff trained in this way become CHCs (see ***The TOT Operational Guidelines***).

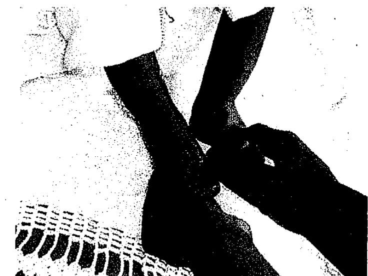
Closing ceremony of CHW training in Chipata

(2) *CHW and NP training at the community level*
CHW training takes 6 weeks (30 days) to be completed whilst NP training takes 2 weeks (10 days). For both training courses, CHCs at each Health Centre catchment area organise the sensitisation for the recruitment of trainees with the NHC and previously trained volunteers for about 2 weeks, and after collecting applications they interview the applicants.

The criteria for the volunteers in the Project have been discussed in Chapter IV (Box 4.3). For CHW training, the guidelines and manuals are in accordance with the national ones. For NP training, the Project developed the ***Guide for Training of Nutrition Promoters and Nutrition Promoters Manual*** and revised the ***Nutrition Counselling Cards***.

The capacity of volunteers in case identification and community referral for under-5 children is also developed and training is conducted in accordance with ***The Guidelines on Child Health Community Referral in Lusaka District***. CHWs are particularly trained for finding cases with general danger signs, who require immediate clinical attention and need to be referred (see ***The General Danger Signs Video***). CHWs are provided with first aid kits and utilise the kits when necessary. Meanwhile, NPs are trained for community screening and referral especially for malnourished children from the community to the Health Centre by using Mid-Upper Arm Circumference (MUAC) tape and checking oedema (swelling). NPs develop their capacity in the use of MUAC and oedema criteria, to enhance their ability to identify malnourished children who need immediate clinical attention.

A first aid kit including ORS, soap, thermometer, GV paints, bandage, cotton wools, referral forms, registration books with a lockable bag



Check of oedema

(3) *Refresher workshops*
Refresher workshops help volunteers to regularly brush up their knowledge and skills as well as to maintain their motivation to continue working as volunteers. Refresher workshops were established on a quarterly basis, and the topics are selected by CHCs, giving consideration to the weaknesses and gaps in volunteers' knowledge and skills, as well as seasonal concerns such as diarrhoea and malaria. Participants take brief pre- and post-tests for the refresher workshops and are assessed for their improvement of knowledge.

C. *Operation of GMP+*

One of the core programmes in the Integrated Community-based Child Health Package is GMP+, which is an integrated programme to prevent diseases and promote children's growth and development. The programme uses the weighing of children as an entry point, going on to include health education, micronutrient supplementation, deworming, nutrition counselling, soya bean promotion, community referral, immunisation and family planning. In the referral system, sick and malnourished children are referred to the nearest Health Centre for further health care and treatment. Follow-up visits are also conducted by community volunteers for underweight children and immunisation and growth monitoring defaulters. Trained community volunteers and staff from each Health Centre organise monthly GMP+ sessions in 9-19 sites per catchment area.

Figure 5.1 Health Services of GMP+

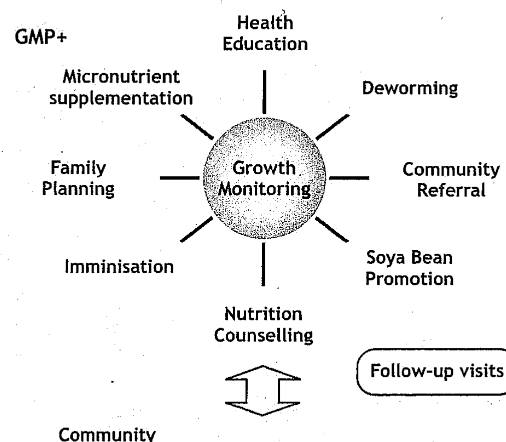
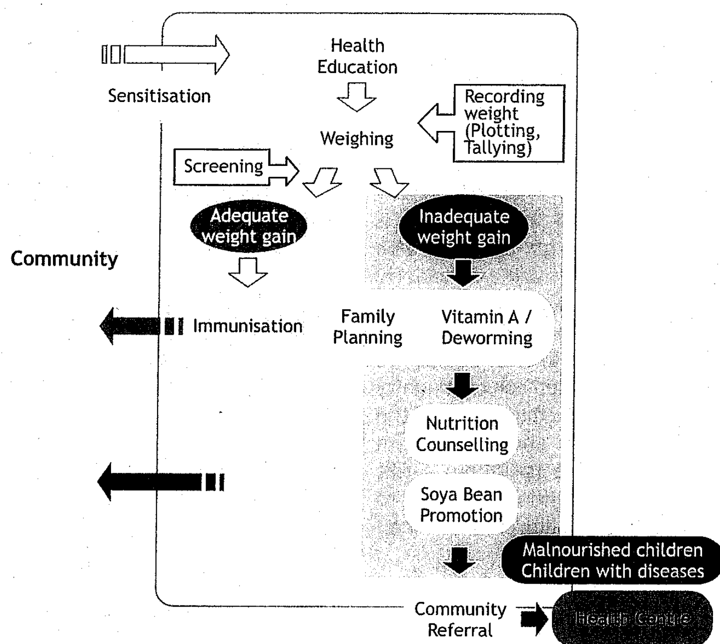


Figure 5.2 GMP+ Flow



The activities are conducted in close coordination between community volunteers and Health Centre staff, and are supervised and monitored by Health Centre staff and the LDHMT, which have responsibilities for planning, funding and training, as well as for the timely and proper implementation of activities. Reasonable planning at each level, timely funding, capacity building, proper supervision/ monitoring and feedback as well as the establishment of a network with other stakeholders are keys to sustain good quality GMP+ activities.

Setting up GMP+ sessions involves the management of logistics, venues, trained volunteers (CHWs and NPs coordinated by the NHC) and Health Centre staff for supervision and carrying out immunisation and family planning services.

Sensitisation of the community for GMP+ at the particular zone is conducted by either the NHC, CHWs or NPs to capture as many participants as possible before the actual day of GMP+ as well as on the day in the morning. Under this Project, desks and chairs as well as the venue itself are normally arranged by the members of the communities themselves, which helps to involve the communities in the activities.

D. *Monitoring and evaluation system for GMP+*

After each GMP+ session, an Activity Report Form is filled in by the representative of the community volunteers and Health Centre staff together. Information such as number in attendance, number of children below the lower line on the growth card, as well as the number of each immunisation received are transferred from tally sheets into the Activity Report Form (see ***The Operational Guidelines on Growth Monitoring Programme Plus***). In addition to the key child health indicators, those conducting the session also assess their own performance on GMP+ for that particular day using a checklist that includes such components as: the condition of preparation considering the availability of equipment, the punctuality of members, and number of volunteers. These are scored on the back of the Activity Report Form.

Health Centre-in-Charge supporting PAI

LDHMT staff conducting PAI

At the end of the last GMP+ session for the month, all the Activity Report Forms for each zone are compiled in a Monthly Return Form, which is submitted to the LDHMT as a Health Centre together with static data.

Based on the collected information from zonal GMP+, monthly monitoring meetings are conducted to share the progress, constraints and ways forward with a view to improving the next GMP+ sessions.

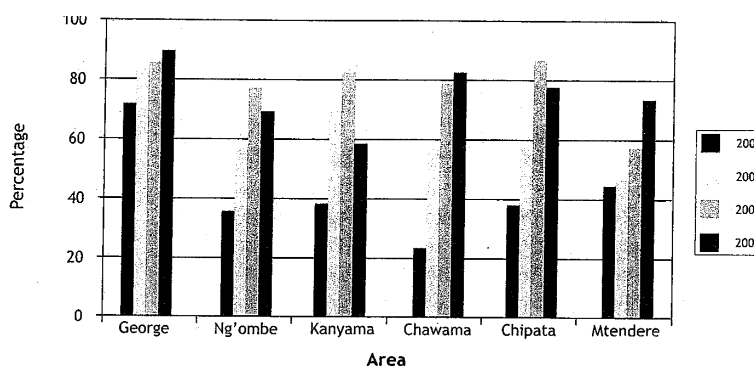
As for community referrals, monthly meetings are also conducted to collect information and to discuss the issues arising. For example, through a referral form to the Health Centre and a feedback form to the community, (see ***The Guidelines on Child Health Community Referral in Lusaka District***) the ratio of cases that reached the Health Centre and the ratio of feedback forms collected by CHWs and NPs are counted monthly, and an inventory is also taken for the supply of items in the first aid kits.

The meetings are facilitated by CHCs, and minutes on the discussion is reported to the Project office. CBO Joint Coordination meetings are organised annually to share common issues to improve GMP+ activities beyond the Health Centre catchment area. Participants of CBO Joint Coordination meetings are 2 CHCs, 1 CHW, NP, EHC member and Basket Fund Committee member and NHC member from each Health Centre catchment area. At the LDHMT level, Performance Assessment for Improvement (PAI) is conducted quarterly apart from regular provincial level Performance Assessment (PA). PAI is employed as a field monitoring tool for GMP+, rather than just keeping track of records at the Health Centre. It is conducted together with the assessment of PA indicators. The team normally consists of MoH coordinators at the DHO assisted by the MCH Coordinator at the Health Centre.

The GMP+ sites in each Health Centre catchment area are randomly chosen for field assessment. The team assesses the performance of GMP+ with the PAI checklist (see ***The Operational Guideline on Growth Monitoring Programme Plus***) for each session, which includes checks on such activities as health education, weighing and immunisation. The team also assesses the situation of planning and record keeping, including the collection of information on PA indicators. Direct feedback is shared immediately after the field assessment of PAI with the host Health Centre staff, and the general comments are shared with CHCs and community volunteers from all the Project Health Centre catchment areas on the occasion of the CBO Joint Coordination meeting.

The comparison of the average performance on GMP+ through PAI is shown below. In 2006, almost every Centre improved their overall performance on GMP+ compared to 2003.

Figure 5.3 Comparison of Average GMP+ Performance by Health Centre



2 Minimum Package of Community-based Environmental Health Activities

Community-based environmental health activities are aimed at reducing water-born diseases such as diarrhoea and cholera through the promotion of behavioural change concerning hygiene and sanitation, and improving sanitation facilities. The methodology adopted for the activities is a participatory approach known as PHAST, and is aimed at achieving the effective mobilisation of resources in communities. The package is implemented using five steps: (1) planning and budgeting, (2) capacity building of facilitators, (3) community mobilisation through PHAST workshop, (4) implementation of planned activities, and (5) monitoring and evaluation.

A. Planning and budgeting

The first step taken in initiating community-based environmental health activities with PHAST methodology was to prioritise and strategise activities at the District and Health Centre levels. The focal persons in planning and budgeting are the Environmental Health Officer at the District level and EHO/EHTs at Health Centre level. Considering needs at both levels and the priority of water-born diseases in areas of concern, the plan and budget for the activities are carefully set out in action plans. As mentioned in the Project Overview, PHAST has been recognised as a prioritised approach by the MoH and the National Health Strategic Plan encourages all the Provinces and Districts to promote such activities.

One of the advantages of the PHAST approach is that community volunteers can make their own plans based on the problems and needs they encounter through the participatory method. EHO/EHTs are encouraged to fully utilise opportunities to design plans and budget jointly with the volunteers.

B. Capacity building of CHCs

The capacity of CHCs in facilitating and supervising the activities with a full understanding of the concept and methodology of PHAST is one of the most crucial factors in implementing successful community-based environmental health activities. PHAST TOT workshops are organised to equip CHCs with knowledge on the methodology as well as skills in the application of PHAST tools.

Facilitator training for EHO/EHTs

The participants of the PHAST TOT are EHO/EHTs, Nutritionists, Nurses, and COs. However, considering the amount of work required for community-based work after the completion of the workshop, the use of EHO/EHTs and Nutritionists, who are able to spare more time for fieldwork, is preferred. The participants are also selected in consideration of the needs of Health Centre catchment areas prioritised by the DHO.

The duration of the workshop is 11 days covering all 45 PHAST tools. The tools are categorised into conceptual, investigative, analytical, planning and operational, and monitoring and evaluation. The workshop combines lectures that cover the purposes and targets of each of the tools and exercises. Although this is a TOT course, participants learn to use the tools as though they were participating in a PHAST workshop.

PHAST workshops are made up of a series of tools starting with conceptual building, followed by problem identification, problem solution and ending in action planning. An important point to be taken into account in organising PHAST workshops is the degree of the effectiveness of the workshop in enabling communities to deeply understand their problems, find solutions and make a feasible plan for their activities. This totally depends upon the capacity of the facilitators in understanding the purposes of each tool and setting up a workshop schedule that incorporates the use of these PHAST tools.

C. Community mobilisation through PHAST workshop

The PHAST workshop is defined as a forum for community representatives to recognise problems that they encounter in terms of hygiene and sanitation and to reach consensus to solve the problems by utilising the available resources in a community. The workshop is organised in a completely participatory manner. The underlying principle is that the best way for a community to change their situation and achieve better hygiene and sanitation is to offer the community chances to take on more responsibility and control over their activities.

The advantage of such a workshop is that it facilitates this process through realising the inner ability of each community member and deepening a sense of ownership in the process.

The preparation process of the workshop - the selection of participants, tools and the schedule of the programme - is a vital part for the fulfilment of the purpose of the workshop. The quality and outcome of the workshop directly influence the implementation of field activities since the commitment and ownership that are brought out through the workshop are key factors in the success of the activities.

(1) *Selection of participants*
The selection of participants is one of the most critical parts of the entire activity. Participants are selected through recommendations from the community and are then interviewed by CHCs based on selection criteria. Selection process and criteria are described in detail in the PHAST Operational Guidelines. The selection process follows these steps:

(a) Recommendation of participants from the community
Candidates for participants are recommended from the community. Requests for recommendations are sent to churches, CBOs, and other stakeholders in the community. Requests are sent to as many organisations as possible since the selection of candidates from a variety of organisations serves to broaden the network of human resources.

(b) Screening of the candidates
The candidates are screened by EHO/EHTs based on the following criteria:

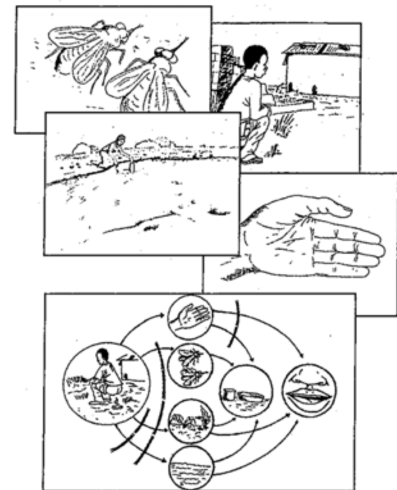
Age between 25-50 years old
Literate in English
Permanent resident

(c) Interview by CHCs
Candidates who are screened are interviewed by CHCs, with the Health Centre-in-Charge also serving as an interviewer. During the interview, emphasis is placed on the apparent commitment and motivation of the candidate to voluntary activities. The appropriate number of participants of the PHAST workshop is between 25 and 30.

(2) *Selection of tools and schedule of the programme*
The duration of the PHAST workshop is 11 days. The workshop follows the steps of conceptual building, problem identification, problem solution, prioritising activities and action planning. These processes are facilitated with the effective utilisation of PHAST visual tools.

The PHAST Tool Manual has 45 PHAST tools. Workshop organisers select tools giving careful consideration to the objectives of the tools. This is important because the sequence of use of the tools can affect the participants' sense of responsibility towards and ownership of activities, and their ability to realise problems and solutions regarding hygiene and sanitation.

Figure 5.4 PHAST Visual Tools



Identifying and Blocking the Transmission Routes

A PHAST workshop in Mtendere

(3) *Conduct PHAST workshop*

In conducting the workshop, the facilitators play the most important role in ensuring that participants are satisfied with the workshop and are able to deepen their motivation and commitment to community activities. The following are the points the Project encourages the facilitators to keep in mind:

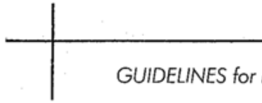
- Participants should not be taught, but assisted to reach the objectives of each session;
- Sufficient time should be allocated to each session;
- An open atmosphere should be created so that all the participants actively join the workshop;
- The progress of the schedule should be flexible taking into account participants' understanding of the sessions.

During the last session of the workshop, participants make a practical and feasible plan of activities that are prioritised to solve problems. In addition, financial resources are carefully detailed giving full consideration to local available resources. Facilitators provide appropriate advice and suggestion in this regard.

Finally, EHCs are formed by the participants themselves. In forming the committee, executive members including chairperson, secretary, and treasurer are selected. Selecting appropriate people for appropriate positions considering responsibility and leadership is important for the management of the committee and implementation of the activities. Some PHAST tools are used for promoting the understanding of good leadership and responsibility.

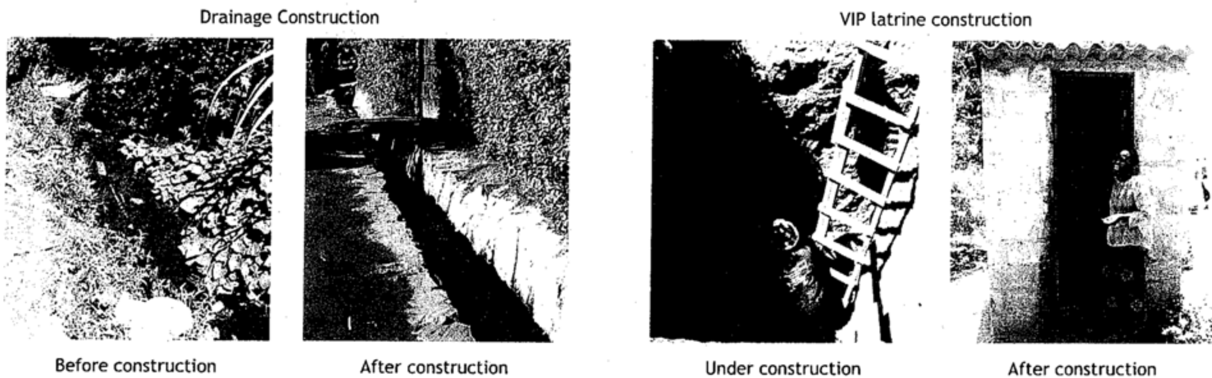
(4) *Follow-up and refresher workshops*

The goal of the PHAST workshop is the mobilisation of community human resources to realise problems and solutions and a deepened sense of ownership and commitment. The workshop does not necessarily cover advanced technical aspects in relation to hygiene and sanitation. Therefore, the Project provides opportunities for continuous learning for the committee members to upgrade their knowledge and skills.



Drainage Construction

VIP latrine construction



Before construction | After construction | Under construction | After construction

Technical workshops are organised before the initiation of the planned activities. Regular refresher workshops also play an important role for the members not only to become equipped with required knowledge and skills but also as a form of incentive to motivate the participants.

D. Implementation of planned activities

Field activities are prioritised and planned by the participants of the workshop. As such, the activities vary depending on the situation where they reside and the problems that they suffer from. However, according to the experiences of the Project so far, typical activities selected were health education, VIP latrine construction, drainage construction and cholera control activities. Selection of activities appears to be influenced by seasonality. The construction of VIP latrines and drainage, for example, tends to be planned in the dry season from April to October, while health education is intensively conducted in the rainy season for the prevention and control of cholera. Detailed activities are described in the ***PHAST Operational Guidelines***.

(1) *Health Education*

Health education has been recognised as an effective approach to provide appropriate knowledge and to encourage behavioural change towards hygiene and sanitation. The Project also adopted a participatory method with PHAST informative tools to intensify the outcome of the health education. The method of health education employed by the committee members neither teaches nor guides residents in a community but encourages them to think together and seek solutions for better hygiene and sanitation. 15 suitable PHAST informative tools are selected from among the 45 PHAST tools (see the ***PHAST Informative Tool Manual and Kit***). Health education is carried out in two ways, public place health education (mass education) and door-to-door health education (small group education).[9] Social marketing of Clorin® is also conducted to encourage people to chlorinate their drinking water.

ealth education is conducted in the
llowing areas:
blic place health education:
markets, churches, schools, water
points, GMP+ sites
oor-to-door health education:
overing all households in
lentified high-risk areas.

(2) *VIP latrine construction*

VIP latrines are designed to minimise contamination of well sources of water and to maximise the life span of the latrine by allowing vacuuming. Due to the high density of the population in the catchment areas, it is advised that a latrine be shared by 2-3 households. In selecting the site and constructing the VIP latrine, the following points are carefully taken into account:

- The latrine pit must be located as far as possible from wells;
- Construction sites must be close to the road side in locations reachable by a vacuum tank;
- The landowner must be the head of the beneficiary group;
- The depositing of an advance at the Health Centre for vacuuming is recommended to ensure ownership and sustainability; and
- Contribution for the construction work by beneficiaries is advisable.

Health education and promotion of Clorin at a GMP+ session in Ng'ombe

(3) *Drainage construction and cleaning*

Drainage construction and cleaning are also often listed as prioritised activities on action plans. The impact of drainage construction is obvious and tangible in avoiding flooding and improving the hygiene situation in the rainy season. The following points are carefully considered in the selection of sites and construction:

Health education with PHAST tools at a community tap in Kanyama

- In the selection of the site, the connection of the constructed drainage to the existing sewage line must be secured;
- Construction sites have to be naturally down-sloped toward the end of the drainage, which makes construction work technically easy and ensures the flow of water; and
- It is recommended that beneficiaries along the drainage contribute to the construction to deepen their sense of ownership.

Volunteers digging drainage in Chipata

(4) *Cholera Prevention and Control*

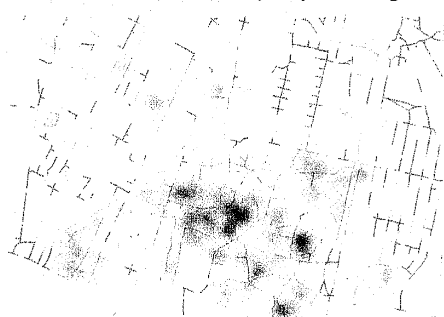
The committee members play essential roles in the prevention and control of cholera outbreaks. Health education and sensitisation for cholera prevention is regularly carried out in communities. In addition, the members also conduct cholera contact tracing with supervision by EHO/EHTs.

The components of the contact tracing are interviews with patients, disinfecting houses of patients and health education.

A cholera contact tracing member disinfecting a patient's house

Figure 5.5 Cholera Epidemic Map

Cholera Patient Density Map in George



The members carry GPS (Geographic Positioning System) recorders with them for recording the geographical locations of the patients - a factor that significantly contributes to the epidemiological analysis of the outbreak.

The contact tracing members are selected from among the committee members and attend a 3-day training workshop that covers technical knowledge on cholera prevention and control and exercise of disinfection (see the ***Step by Step Guide for Cholera Prevention and Control***)

E. Monitoring and evaluation

A monitoring cycle of the activities is daily, monthly and yearly. The committee members report daily activities with a daily activity report form that is submitted to EHO/EHTs. Monthly monitoring is done at the monthly meeting of the committee. Based on this monitoring, the committee plans for the following period. EHO/EHTs are also requested to monitor on a quarterly basis.

3 Minimum Package for Strengthening Health Administrative Management

It is essential to strengthen the planning and financial capacity of health administrative management in order to implement community-based child health activities effectively. As such, several activities were identified and have been implemented to supplement and improve routine administrative management activities.

A. Lusaka District Health Data Book 1998-2004 and Lusaka District Health Data Bulletin 2005

One approach that could be used to strengthen the LDHMT's planning capacity would be to make evidence-based plans. Even though the Health Management Information System (HMIS) was introduced in 1998 as a way to share health-related evidence, it was still difficult to access the information collected from Health Centres. In order to overcome this situation, the Lusaka District Health Data Book 1998-2004 was developed.

The Data Book consists of HMIS data of the Lusaka District as well as data on the health and socio-economic status of Lusaka and Zambia in general from other sources. Health data is arranged to show the trends in the health status of each Health Centre catchment area over 7 years, which helps Health Centre staff analyse the health status of their catchment area and make it easier to develop annual action plans.

The Book is not only the starting point for evidence-based decision making in planning and programme implementation but also serves to promote improvement in the quality of data. A Health Data Book Working Group was formed to understand the main health and management problems in the District and provide the basis for evidence-based health data through developing the Health Data Book. The Working Group then acquired HMIS data from the Lusaka District as well as data from the Central Statistical Office and other various sources relevant to the health status of the Lusaka District, discussed how to design the Book and then proceeded to draft it. The Book was distributed to all Health Centres in Lusaka in May 2005.

In 2006, the same Working Group was organised to develop the Lusaka District Health Data Bulletin 2005 that served to update the information from HMIS and other sources. Questionnaires were developed and sent to all Health Centres to collect information that was not acquired from HMIS. In addition, simplified data entry formats were developed. The LDHMT plans to publish the Health Data Bulletin annually and the Data Book every 6 years under the leadership of the Managers of Planning and Development in close collaboration with HMIS staff in the LDHMT.

B. Lusaka District Health Strategic Plan

In 2003, the LDHMT produced action plans annually. A strategic plan existed at only the national level. The National Health Strategic Plan 2001-2005 covered the problems Lusaka District also faced and the LDHMT followed its direction. However, certain priorities at the LDHMT level did not necessarily match those at the national level. In addition, it was crucial for the LDHMT to clarify its future direction by showing clear vision, mission, goals and objectives and to identify strategies to accomplish them. Therefore, it was decided to develop the Lusaka District Health Strategic Plan 2004-2006 to add to the annual action plans.

For the development of this Strategic Plan, discussions with LDHMT counterparts continued for several months through weekly meetings and the formation of the Working Group. At the same time, collection of information, situation analysis and analysis of existing statistical data were conducted. Through these processes, vision, mission, goals and objectives were clarified and strategies were identified.

The Lusaka District Health Strategic Plan 2004-2006 was published in May 2004. GMP+ and PHAST were clearly described as strategies to reduce the morbidity and mortality from preventable illnesses in under-5 children as well as from pneumonia, malaria and diarrhoeal diseases in people of all ages. The Managers of Planning and Development in the LDHMT take the lead in developing this Plan every 6 years following the National Health Strategic Plan.

C. Prioritised Action Plan (PAP)

PAPs are a part of the annual action planning process conducted by the LDHMT and are produced by Health Centres as well as by the DHO. They aim at prioritising and describing activities in the annual action plans in a logical, simple and clear manner for information sharing and at linking strategy, plan and budget. Prioritised activities are those that need to be focused on, and are meant to enable the achievement of specific goals within specific time periods.

The PAP Working Group was established to understand the main health and management problems and to provide the basis for efficient and effective planning for the six target Health Centres through developing PAPs. Through several workshops and meetings, formats were developed and each of the six Health Centres produced their own PAPs, in which they all identified GMP+ and PHAST as their prioritised activities. Based on these experiences and feedback from the workshops, ***A Manual for A Prioritised Action Plan*** was developed.

The concept of PAP was introduced to other departments of the DHO as well as to other Health Centres in 2005 at an annual planning workshop, after which all 28 Health Centres produced the PAP for 2006.

The formats were revised in 2006 to make them more user friendly and to incorporate feedback from monitoring meetings. Another orientation was organised for all Health Centres and the DHO to introduce revised formats and reorient those concerned with the need to prioritise activities and the importance of indicators as monitoring tools.

Despite inadequate funds to implement the prioritised activities, it is important to monitor activities by using monitoring sheets. It is considered that the monitoring should be incorporated in the Performance Assessment and technical support visits conducted by the LDHMT.

D. Financial Working Group

The Financial Working Group was established in 2005 to facilitate the efficient and effective allocation of scarce resources for the improvement of the health status of Lusaka District. It conducts financial analysis for Lusaka District, works to improve of the accountability and transparency of finances and to strengthen knowledge on financial accountability at the District and Health Centre levels. It complements the function of the Finance Committee in the DHO.

As a first step, the Finance Working Group conducted a SWOT (Strength, Weakness, Opportunity and Threat) analysis. Based on the results of the analysis, the Group planned several activities to improve the situation.

Several financial management and HMIS orientation sessions were organised for staff in the DHO as well as the Health Centres.

The Group developed a financial report for 2005 to share the LDHMT financial situation and problems with the DHO and all Health Centres. The financial report for 2006 was incorporated into the District Annual Report 2006 by the staff of Accounts. In addition, Accounts in the DHO continues to provide useful information to staff in the Health Centres through the Monthly Information Bulletin.

Through these efforts, accountability and transparency in financial management at the DHO level has improved, and knowledge on financial and administrative management has been strengthened.

The involvement of Health Centre-in-Charges is one of the important factors in making the Financial Working Group functional and realistic. Further efforts are required by the Group to improve the timely disbursement of funds for planned activities, submission of monthly income and expenditure reports from Health Centres and financial documentation against planned activities. The Managers of Planning and Development take the lead in organising regular meetings with the Secretariat from Accounts, Personnel and HMIS.

E. Monthly Information Bulletin

Lack of information sharing was identified as one of weaknesses in the administrative management of the LDHMT. The Financial Working Group made a decision to issue a Monthly Information Bulletin to fill information gaps, especially between the DHO and Health Centres. The first Monthly Information Bulletin was issued in January 2006. Since then, the Accounts department has been writing an article every month to share financial information with the Health Centres, and other programme and department managers in the DHO have been requested to submit articles on their own activities.

Despite inadequate distribution and sharing of the Bulletin at a Health Centre level, the Monthly Information Bulletin has become more popular among staff and they have learned that there is useful information in it. Furthermore, staff at the DHO realise that it is a useful tool to forward information to Health Centres. The Managers of Planning and Development identified one key person in the Office to have the responsibility to collect articles and edit them for monthly publication in the Bulletin.

The Monthly Information Bulletin is a tool to provide information from the DHO at the moment. It is considered, however, that feedback from the Health Centres is also important to further improve information gaps between the DHO and Health Centres.

A Registry in a HC

Before the introduction of 5S

After the introduction of 5S

F. 5S

5S was introduced as a starting point of Continuous Quality Improvement (CQI). The concept of 5S, is originally based on the Japanese words: seiri (sort), seiton (set), seiso (shine), seiketsu (standardise) and shitsuke (sustain or self-discipline).

5S activities are used as aids to enhance the motivation of staff. They are concrete and easy to implement, and moreover, visible results can be obtained within a relatively short period of time. 5S activities aim at making workplaces efficient and work environments enjoyable for staff through active involvement in the activities.

Firstly, 2 representatives from each of the six target Health Centres were oriented on 5S in 2005. They organised 5S Committees inviting representatives from each department in their Health Centres and briefed them about the concept of 5S. After that, the Committee members organised 5S orientation sessions for all staff. Through a monthly meeting, the Committee identified problems and developed a quarterly plan on 5S activities such as Big Clean-Up Days to facilitate the participation of all staff, improvement of registries, exit interviews, and assessments using a rating form and award system. The 5S Coordinator in the DHO holds a 5S focal person's meeting monthly, to share each Health Centres experiences and problems, and to discuss how to solve these problems. Facing inadequate funds to implement 5S activities, each Health Centre has started income generating activities to sustain 5S activities.

5S was introduced to all other Health Centres in Lusaka District and the DHO through orientation to 2 representatives from each in 2006. The six target Health Centres are acting as spearheads for further promotion of 5S to other Health Centres.

4 Minimum Package for Financial Sustainability of Community-based Activities

The minimum package of activities for financial sustainability covers the establishment of a solid Community Basket Fund System at the Health Centre level.

A. Training of Trainers (TOT) on business management

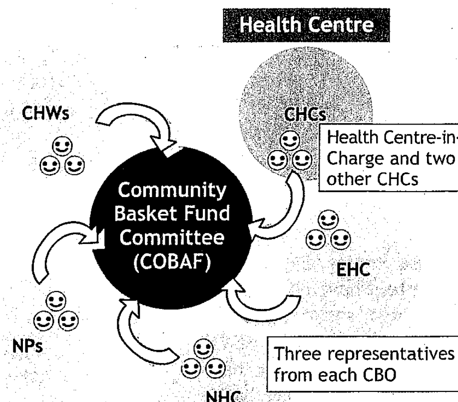
CHCs at each Health Centre are trained in business management, covering marketing, costing, budgeting, purchasing, stock control, accounting and record-keeping. Trained CHCs are expected to be trainers who conduct this training for CBO members and to serve as supervisors of the business activities of CBOs.

B. *Formation and capacity building of the Community Basket Fund Committee*

A Community Basket Fund Committee was formed at each Health Centre by the representatives of stakeholders (Health Centre staff and members of CBOs). In the Project, members of the Community Basket Fund Committee are 15 in total, of which 3 are CHCs and 3 each are representatives of CHWs, NPs, the EHC and the NHC. The Health Centre-in-Charge is included among the Committee members.

The Committee elects a chairperson, a secretary and a treasurer from among the non-Health Centre staff. The Committee is responsible for the management of the businesses, which includes budgeting, purchasing, staffing, accounting and stock control. After the formation of the Committee, training is given to the Committee members by the trained CHCs.

Figure 5.6 Community Basket Fund Committee



C. *Selection of IGVs and financial support*

The Committee selects one or more IGVs based on their observations and analyses to confirm if the selected IGV(s) matches the following conditions:

- There are sufficient demands and needs for the selected business (marketing research)
- It is not a complicated type of business which is difficult for the Committee members to run

Marketing research by Community Basket Fund Committee members

In this Project, fee-paying toilets and showers, and hammer mill services were selected as IGVs by the Committee. These businesses in fact found certain demands in the target areas and do not require special knowledge or skills in their operation and management.

After the selection of proper IGVs, the Committees are given the necessary financial support to construct the facilities and purchase the materials within the budget.

D. *Support for running the IGVs*

Until the business starts producing some profits, Committees are supported technically and financially, assuming that the Committee members may not have much experience in running a business. Technical support is particularly important in record-keeping and financial support is needed to cover running costs (wages for workers, utility expenses, maintenance costs, etc.) until profits can be generated to cover these costs.

E. *Supervision and monitoring by CHCs*

After the business gains momentum, the supervision and monitoring of the activities by CHCs are gradually systematised. The major tasks of CHCs at this stage are as follows: (For further detail, refer to the Guideline for Community Health Coordinators to supervise the Community Basket Fund Committee activities).

(1) Daily tasks
- Checking accounting records and receipts
- Keeping money safely in the Health Centre[10]

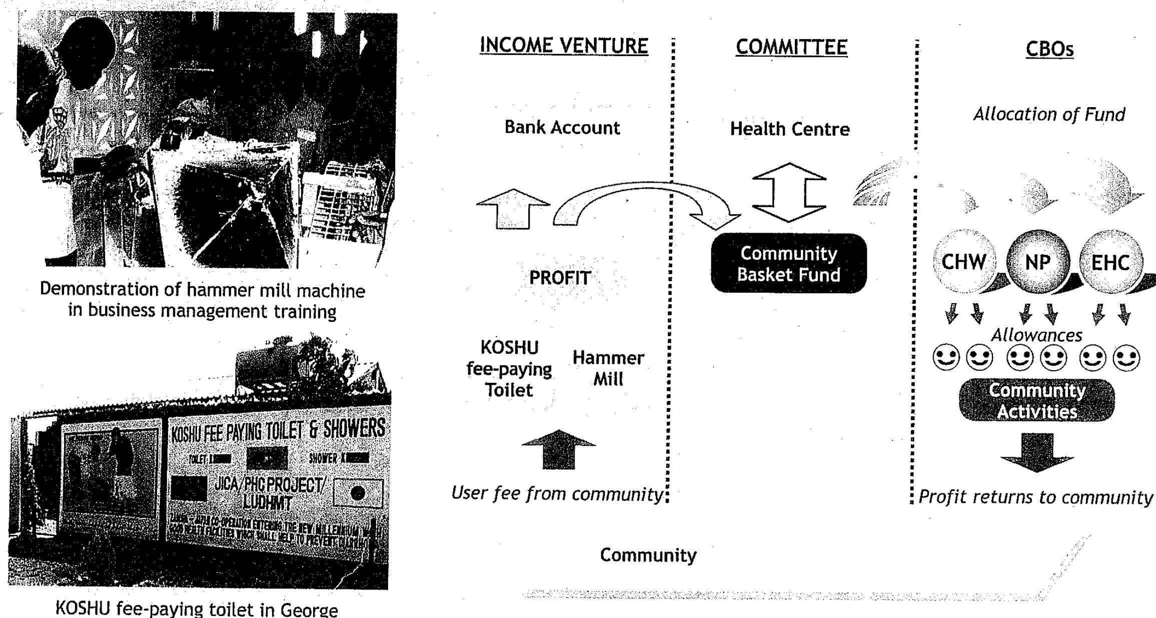
(2) Monthly tasks
- Auditing accounting records internally
- Analysing business performance (income, expenditure and profit) and giving advice to improve the business

(3) Other regular tasks
- Attending the Community Basket Fund Committee meeting
- Controlling and approving the expenditure
- Checking if maintenance and cleaning are properly done at the site
- Checking stocks and stock keeping records

[10] The community Basket Fund committees have opened bank accounts for security purposes. The money kept at the Health Centre is transferred to the bank account periodically.

As accountability and transparency are keys for the sustainability of the Community Basket Fund System, regular checking of the accounting records is important. Besides the supervision conducted by the CHCs, an annual audit is to be conducted by the District.

Figure 5.7 Community Basket Fund Mechanism



F. Provision of incentives

Monthly profits of the IGVs are used as incentives for the volunteers of the target CBOs. The amount of the incentive for each volunteer is calculated by CHCs depending on the level of their commitment. (for detail, refer to the ***Guideline for Community Health Coordinators to supervise the Community Basket Fund Committee activities***).

The Community Basket Fund System is finally complete at this stage. In the Project, profits generated are also utilised for supplemental financial support for the activities of CBOs after some portion is deposited for maintenance purposes.

5 Minimum Package for Institutionalisation of the Network among CBOs at a Local Level

In Zambia, NHCs have been introduced in almost all the Health Centre catchment areas to serve as a link between the Health Centre and the community since the Health Sector Reforms in 1994. The Project has institutionalised networks among local CBOs and the community through the strengthening of the NHC.

A. Support for the formation of NHCs

NHCs are made up of representatives selected by their communities. The selection of the members is done in a democratic way. The Project supported the election of NHC members in the target areas. After the NHC members are selected, they form a unit NHC that consists of 10 members, each of which elects a chairperson, a secretary and a treasurer from among the members. The chairpersons of unit NHCs finally form the NHC Health Centre Committee (HCC), which also has a chairperson, a secretary,[11] and a treasurer. The formation of the NHC from unit level to HCC level can be supported according to the ***Guideline for Activities of the Neighbourhood Health Committee (NHC) in Lusaka District***.

[11] The secretary of the NHC HCC is the Health Centre-in-Charge.

B. Capacity building of NHCs

The NHC is expected to function as the mother body of all the CBOs in their Health Centre catchment area, as well as a link between the Health Centre and the community. It is important that they be given opportunities to develop their capacity to accomplish these roles.

The Project supports the capacity building of NHC members through orientation and Basic Health Care Package (BHCP) training facilitated by CHCs. Both forms of training are given to all the NHC members at an early stage after its formation.

Orientation is organised for 1-2 days and includes such components as: mission and roles of the NHC, structure of the NHC, and relation with the Health Centre. The BHCP was established by the MoH in the 1990s. The duration of the training is 3-5 days.

C. *Support for regular activities*

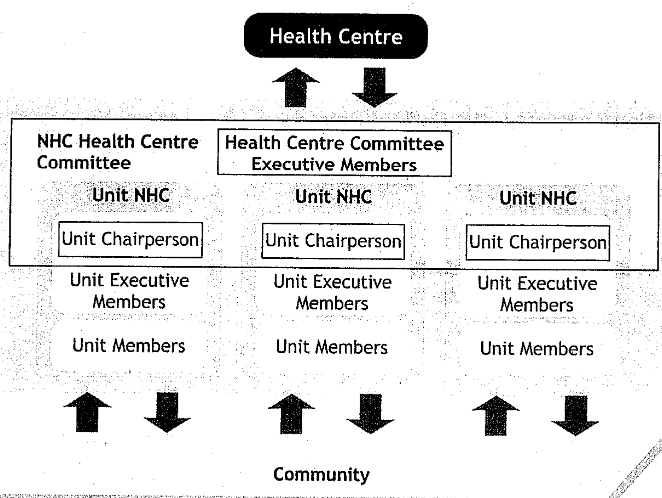
After NHC members have been trained, they start to regularly hold monthly (or quarterly) meetings at the Health Centre and unit level. Members are supposed to report on the health matters in their areas to their Health Centre. Holding these meetings strengthens the network and communication not only among NHC members but also within the community, and further serves to build a firm link between the community and the Health Centre. CBO joint meetings are held at the Health Centre level with representatives of other CBOs in the area, which can improve the coordination among CBOs through their networking and close communication. The Project has monitored these regular meetings by attending them with CHCs. The contributions of Health Centre staff in the meetings, especially the Health Centre-in-Charge, encourage them to continue their routine works.

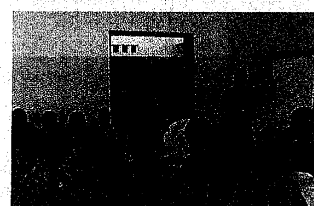
D. *Annual General Meeting of NHCs*

All the NHCs and Health Centre staff in the District have the opportunity to meet on an annual basis. The Annual General Meeting is held for the following purposes:

- To receive the HCC reports from each area and adopt them if appropriate
- To receive the HCC level treasurer's reports from each area and adopt them if appropriate
- To share information, exchange opinions and conduct any other business

Figure 5.8 Formation of Neighbourhood Health Committee





Basic Health Care Package training for the NHC in Chipata

Group discussion in the first Annual General Meeting of the NHCs in Lusaka