



**EVALUATION OF THE PREVENTION AND CONTROL OF
HIV/AIDS AND STDS IN WOMEN THROUGH THE
INTEGRATION OF STD/HIV/AIDS SERVICES INTO
MATERNAL CHILD HEALTH/FAMILY PLANNING
FACILITIES IN 5 URBAN DISTRICTS.**

FINAL REPORT



JULY 2001

GLOSSARY

ANC	Ante-natal Care
AusAID	Australian Agency for International Development
ARC	AIDS Related Condition
CBOH	Central Board of Health
CBO	Community Distribution Officer
CHW	Community Health Worker
DHMB	District Health Management Board
DHMT	District Health Management Team
DOTS	Directly Observed Treatment Short-course
FAMS	Financial Administration Management System
FP	Family Planning
GRZ	Government of Republic of Zambia
HMIS	Health Management Information System
IEC	Information, Education and Communication
MCH	Maternal and Child Health
MTCT	Mother to Child Transmission
NGO	Non-governmental Organisation
NHC	Neighbourhood Health Committee
OPD	Out-patient Department
PCSP	Prevention and Control of Syphilis Project
RPR	Rapid Plasma Reagin
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
UNAIDS	Joint UN Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
YAB	Youth Advisory Boards
YFHS	Youth Friendly Health Services
ZIHP	Zambia Integrated Health Programme

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SUMMARY

This project, *The prevention and control of HIV/AIDS and STDs in women through the integration of STD/HIV/AIDS services into maternal child health/family planning facilities in 5 urban districts in Zambia*, was managed by UNICEF Zambia and funded through the Australian government and UNICEF Australia. The project commenced in June 1998 and is due for completion in September 2001. Its components are:

- Training of health workers in STD/HIV/AIDS diagnosis, treatment and counselling
- Implementation of STD/HIV protocols within MCH/FP facilities at hospital and health centres
- Social mobilisation and development of appropriate IEC materials on STD/HIV/AIDS for women attending ante-natal, postnatal and family planning clinics, their partners and the community
- Monitoring and evaluation.

A final evaluation of this project was conducted during May 2001 to examine the actual achievements of the project, in relation to the objectives and outputs as set out in the project proposal.

The evaluation found that this Project has achieved some success in integrating STD/HIV/AIDS services to MCH/FP facilities. It was also evident that health centre staff had skills and confidence to conduct screening using sexually transmissible infections (STI) syndromic management and that their knowledge and skills had been increased through training, support and supervision. There has been an increase in the number of women being screened at MCH/FP facilities however there was also a trend of fewer women (and their partners) being treated for STIs, despite evidence of increasing number of STIs in the community. The widespread lack of free drugs and reagents is likely to be the most significant reason for this decrease as fewer people are able to receive treatment through health centres or are referred elsewhere. A significant concern was that screening rates for syphilis had dropped since 1999 due to lack of RPR kits and staff were discouraged about the quality and effectiveness of the service that they were able to provide. As a result, rates of congenital syphilis appear to be increasing. There was also a disturbingly higher number of ulcerative STIs (syphilis and chancroid) as opposed to the inflammatory varieties (gonorrhoea, chlamydia etc.), a worrying development with the high HIV prevalence rates in the country.

Although STI case management was being implemented with some success in most health centres, HIV/AIDS services require further development. Specifically, voluntary counselling and testing (VCT) and Mother to Child Transmission (MTCT), or Parent to Child Transmission (PTCT), services need to be increased and staff supported through training and supervision to provide accurate information and establish appropriate referral processes. Staff need further skills in counselling and VCT sites should be expanded and linked more closely with MCH/FP facilities. Mother to child transmission (MTCT) services need to be expanded to include a comprehensive package of care for mothers, however, this package would need to be carefully structured according to the staff skills and resources available through health centres and districts. The issue of anti-retroviral drugs has a very strong bearing on the success of MTCT programs.

Demand for VCT is slowly increasing however it is limited by staff reluctance to raise and discuss HIV/AIDS issues with clients. A climate of fear and stigma still exists within communities in relation to HIV/AIDS, although there are many efforts to combat discriminatory practices. Health care and community workers need much more training on attitudes and practices, including confidentiality, related to HIV/AIDS and clear procedures for referral and ongoing community care, to begin to truly address HIV/AIDS within these facilities.

There has been a strong community mobilisation effort through the project and the range of prevention activities that have been implemented is impressive, as is the enthusiasm and commitment from community members. The lack of IEC materials and the inconsistent supplies of condoms have made these efforts more difficult and potentially reduce the impact of these activities within communities. Finding ways to sustain these efforts is essential as peer-led activities and community involvement can create long term changes in people's behaviour.

Recommendations for further project activities focus on strengthening training of health care workers, specifically in HIV/AIDS counselling and MTCT issues as well as attitudes and confidentiality in relation to HIV/AIDS. It was also recommended that STI/HIV/AIDS clinical activities be consolidated through more reliable supply systems, refresher courses in syndromic management and counselling, and a stronger focus on VCT and MTCT programmes. Youth programmes should also be strengthened through training, provision of IEC material and support for prevention efforts. The peer educators used in the youth component need to be supported to reduce the drop-out and the subsequent need to train new ones.

It is recommended that the current project receive short term bridging funding to consolidate and strengthen these areas and that funding is sought for this project to continue and be scaled up in the longer term, provided that there has been some effort to address the constraints that have affected the current project.

1.0 Background

1.1 Epidemiology and current situation of STI/HIV/AIDS in Zambia

Zambia is at the heart of the African AIDS belt, which stretches from Uganda and Kenya southward to South Africa. In 1998, the HIV prevalence rate across the country was estimated to be 19.7%. Within the 15 to 49 age groups, this rate varies across the country, from 11.7% to 27.3%.¹ In some urban populations this rate is as high as 28%, and in rural areas around 14%. The estimated number of people living with HIV/AIDS in Zambia at the end of 1998 was 1 million, although only 45,000 cases have been reported to the Ministry of Health. Within the sexually active population, HIV prevalence is far higher in females: HIV infection rates for 15-19 year old females are five times those of males in the same age cohort and females in the 20 to 29 age group are three times more likely to be infected. Factors that may contribute to this difference are young women are being infected by older men and younger women are more physically vulnerable to HIV infection. From age 30 however, men show higher rates of HIV. There was encouraging evidence from the 1998 sentinel surveillance data that suggests that rates of HIV have declined among the 15 to 19 year age group, particularly in Lusaka and Ndola.¹

Among antenatal clinic attendees there has been a frightening increase in HIV prevalence. In Lusaka, where 90% of women visit antenatal clinics at least once a week during their pregnancy, HIV prevalence rates increased from 25% to 32% between 1990 and 1994. These figures are supported by a 1996 population based study in Lusaka and Kapiri Mposhi (a small town some 2 hours north of the capital) showing prevalence rates ranging from 16.5% in rural areas to 31% in the peri urban areas with urban prevalence at 26.2%. However, there has been a drop to 29.5% (urban) and 27.2% generally. The other project sites have similarly high HIV/AIDS prevalence rates: Ndola (28.4%), Kitwe (28.7%), Chipata (17.9%) and Livingstone (31.0%).

Even before the advent of HIV/AIDS, STIs have been a major public health problem in Zambia. With an estimated 200,000 to 300,000 new cases of STIs occurring per year, STIs represent the commonest reported cause of adult attendance in Zambia. Available evidence not only suggests that women are more vulnerable to acquiring STIs, but less likely to seek treatment and more likely to be misdiagnosed when they seek medical care. Studies in Ndola have shown that 11.3% and 14.0% of men and women were infected with syphilis, while two out of every three sex workers in Ndola had a sexually transmitted disease. Newer studies have shown higher STI infection rates in sex workers in Chipata, Chirundu and Livingstone of 36%, with genital ulcers being higher (28%) than discharges (24%).²

STIs such as genital ulcers can increase the effectiveness of HIV transmission from 6 to 18 times. The relation between STIs and HIV infection is well illustrated by UTH's STI clinic records that showed, in 1992, some 70% of the STI clinic attendees to be HIV positive. Other recent studies

¹ Ministry of Health/Central Board of Health: HIV/AIDS in Zambia 2000 - Background Projections, Impacts, Interventions. Ministry of Health/Central Board of Health, Lusaka 1999.

¹ Family Health International. Behavioural Surveillance Survey, Zambia 2000 – Sex Workers. FHI, Arlington 2000.

have shown a range of 40 to 60%. In addition, STIs produce a significant burden of mortality particularly for women and newborns.

The relationship between STIs and HIV transmission through direct, biological mechanisms is well understood and early treatment for STIs is considered to be an essential element in HIV prevention strategies. WHO has recommended the use of syndromic case management for treatment of STIs since 1990. This approach has been demonstrated to be cost-effective and suitable for health centres that have limited resources, especially laboratory facilities. Patients are treated on the basis of their symptoms and compliance is enhanced through patients being able to be treated at the place and time of first contact, reducing the opportunity for patients to be “lost” to treatment where there are several stages for referral. While this approach may have some limitations as a screening tool to detect cervical infection in asymptomatic populations, it has been shown to be effective in managing urethral discharge and genital ulcer disease.³

The growing prevalence of STIs and HIV/AIDS among pregnant women is the result of a number of factors. STI diagnosis and management capacity is equally poor in both OPD and MCH/FP clinics. Few staff have been properly trained in STI case management and diagnostic capacities are weak. Referral procedures to STI clinics are unclear, compliance is low, there is little follow up on referral patients, and most services suffer from insufficient logistics, monitoring and supervisory support.

Between 1991 and 1994, a trial conducted in the Mwanza region, Tanzania, to integrate syndromic STI case management into primary health care services, demonstrated a reduction of 38% in HIV incidence in the general population over two years. This study showed that clear guidelines, training of health care workers, reliable provision of low-cost drugs, regular supervision and health education campaigns within the community were essential components for improved services.⁴ As a result of this and other studies, five elements for the implementation of STI prevention and care are described: assessment; advocacy, strengthening STI services; integration of STI prevention and care; and, evaluation of interventions.⁵ This comprehensive approach requires particular attention to development of clear policies and guidelines, health worker training, sufficient resources, supervisory practices, consistent drug and clinic supplies, and counselling and patient education.

UNAIDS also proposes that STI control programmes include the following components:⁶

- Promoting safer sex behaviour
- Strengthening condom programming
- Integrating STD control into primary health care and other health care services
- Providing specific services for populations at increased risk
- Comprehensive case management

³ Pettifor A, Walsh et al. How effective is syndromic management of STDs: A review of current studies. *Sex Transm Dis* 2000 August; 27(7):371-85

⁴ Grosskurth H, Mwijarubi E, Todd J et al. Operational performance of a STD control programme in Mwanza region, Tanzania. *Sex Transm Inf* 2000; 76:426-436

⁵ UNAIDS. Consultation on STD interventions for preventing HIV: what is the evidence? UNAIDS/WHO 2000

⁶ UNAIDS Technical Update. The public health approach to STD control. May 1998.

- Prevention and care of congenital syphilis and neonatal conjunctivitis
- Early detection of asymptomatic and symptomatic infections.

Since 1994, integration of STI and HIV services with primary health care has been advocated widely as a way to improve women's reproductive health and to control the spread of HIV. However this approach has also been limited by political, managerial and financial constraints in a number of countries. Some of the constraints to successful integration include difficulties in managing change within existing structures and systems, facilitating collaboration between vertical programmes and activities and expectations of external donors.⁷

1.3 Prevention and Control of Syphilis in Pregnancy Project

To address the high rates of genital ulceration, the Australian government funded a project for the Prevention and Control of Syphilis in Pregnancy (PCSP) between 1994 and 1998. This project was initially conducted in Lusaka then expanded to Ndola, Livingstone, Kitwe and Chipata. This project aimed to improve the quality of antenatal care through health education, screening and treatment of all pregnant women and their partners, to promote early attendance at antenatal services and increase access for young women and girls to health services.

An evaluation of this project, conducted in 1998, found that the project reached 48% of expectant mothers in the project districts and screened on average 84% of all ANC clients. Strategies to use clinic nurses to screen for syphilis using RPR tests were effective and systems for supervision of clinic staff were established. During this project Youth Friendly Health Services (YFHS) were established in two districts. The main constraints identified included the process of health sector reforms, staff shortages and inconsistent supplies, poor quality control of test kits resulting in a high number of false positive RPR tests and drug wastage. Among the recommendations was continued support for districts to improve data management and quality control of RPR screening processes and the development of IEC and community mobilisation strategies to target early registration for ANC.

1.4 Current Project

Following the success of the PCSP, UNICEF Zambia, with the assistance of the Australian Government and UNICEF Australia, supported the development and implementation of a programme designed to contribute to reduction of prevalence of STIs and HIV/AIDS among women in five urban districts - Lusaka, Ndola, Kitwe, Livingstone and Chipata (same districts as PMSP) - through these ongoing health reforms. This was in accordance with the goals of UNICEF Zambia's Program of Cooperation which included to halt increases in HIV infection rates and stabilise HIV infection rates for rural and urban adults of reproductive age at 15% and 25% respectively.

The objectives of this project are:

⁷ Lush L, Cleland J, Walt G, Mayhew S. Integrating reproductive health: myth and ideology. *Bulletin of World Health Organization* 1999;77(9):771-7.

- a) To provide all child bearing age women attending MCH/FP clinics access to STD/HIV/AIDS services to reduce the prevalence of HIV/AIDS/STD; and
- b) To improve the quality of HIV/AIDS/STD care through the integration of STD/HIV/AIDS services into 80 MCH/FP facilities.

The project commenced in June 1998 and its components are:

- Training of health workers in STD/HIV/AIDS diagnosis, treatment and counselling
- Implementation of STD/HIV protocols within MCH/FP facilities at hospital and health centres
- Social mobilisation and development of appropriate IEC materials on STD/HIV/AIDS for women attending ante-natal, postnatal and family planning clinics, their partners and the community
- Monitoring and evaluation.

Funding for this three-year project was A\$1,011,590. The sources of funding were:

Source of funds	1998/1999 (A\$)	1999/2000 (A\$)	2000/2001 (A\$)	Total (A\$)
AusAID	187,000	250,000	312,000	750,000
UNICEF Australia	122,500	65,750	17,840	209,090
UNICEF Zambia	52,500	0	0	52,500

2.0 Purpose and method of evaluation

The final evaluation of the project was commissioned by UNICEF Australia and UNICEF Zambia prior to its completion of the project, due in September 2001. The team comprised an Australian HIV/AIDS consultant, Anne Malcolm, a local STI/HIV/AIDS consultant, Dr. Kanyanta Sunkutu, a Central Board of Health Representative, Dr. Elijah Sinyinza, a UNICEF Zambia Representative, Christine Mutungwa and the officer responsible for the project at UNICEF Australia, Sarah Lendon. The team was also joined by Dr Marzio Babilie from UNICEF Zambia for field trips to Ndola, Kitwe and Kabwe districts.

The purpose of the evaluation was to examine the actual achievements of the project, in relation to the objectives and outputs as set out in the project proposal. Specifically, this evaluation was to undertake a review of the progress, experiences and lessons learnt and to identify issues and challenges that needed to be addressed in order to scale up the project. Terms of reference for the evaluation are included as Appendix 2.

2.1 Methods of the evaluation

This formative evaluation was conducted from 7th to 17th May 2001. The team met with key UNICEF staff in the Zambia office, representatives from UN, government and NGO agencies in Lusaka and then undertook field visits to four of the five districts, Lusaka, Livingstone, Ndola and Kitwe. For comparison, the team also visited Kabwe, a non-project district. In these districts, the team visited selected government centres, community centres and private clinics. Time constraints prevented the team from visiting Chipata district, however reports and documents

from the Chipata DHMT were reviewed and assessed. The evaluation itinerary is attached at Appendix 3.

To assess the range of clinic services across districts, DHMT staff were requested to nominate high and low performing services in their area and develop a program for the team to visit these centres. The team also requested to visit private clinics to compare these services to those operated by government. In Lusaka, Livingstone, Ndola and Kitwe, the team visited 4 to 6 centres and in Kabwe, 2 centres were visited. Due to the schedule, the team was unable to visit any hospitals, however several centres with outpatient departments were visited.

The evaluation used quantitative and qualitative methods to collect and analyse the data. Qualitative assessment was undertaken through interviews using focused questions with DHMT and clinic staff, key donor agency representatives, CBOH representatives and NGO organisations. The team also conducted group discussions with youth peer educators and Neighbourhood Health Committee members. A list of people consulted during the evaluation is attached as Appendix 4.

Qualitative data was analysed though the themes identified from the interviews. Quantitative data that was assessed included performance indicators collected through health centres each quarter and the district reports on project activities, available through UNICEF Zambia office. This information was analysed against targeted activity outputs of the project.

Prior to leaving Zambia, a debriefing session was held with relevant UNICEF staff, key donor, CBOH and DHMT representatives, setting out some preliminary conclusions and recommendations.

A draft report was completed by the team in Australia and Zambia. The draft was sent to UNICEF Zambia and other relevant stakeholders for comment. Comments received were taken into account in the finalisation of the report.

3.0 Project performance

In this section each of the Project's components are reviewed in turn. Commentary is provided on design issues where relevant, the outputs of each component, the extent to which expected progress has been achieved, and the key areas that have constrained progress to date.

The discussion of progress and issues in the section are supported by a summary table in logframe format attached as Appendix 1.

3.1 Component 1 – Training of health workers in STD/HIV/AIDS diagnosis, treatment and counselling

The design of this component focused on training a range of health staff and community health workers to provide appropriate services within health centres and at the community level. Activities include a range of training programmes for nurses, clinical officers, community health workers and Traditional Birth Attendants (TBA). This training was organised and conducted through District Health Management Teams (DHMT) in the five project districts.

Areas covered by training included syndromic management, integration of STI/HIV/AIDS, issues relating to STI/HIV/AIDS, voluntary counselling and testing (VCT), communication, mother to child transmission of HIV (MTCT) and infant feeding options as well as youth friendly services. This training initially occurred with key health workers who were trained as trainers, followed by training for a range of health care staff. Training sessions were varied in length and included lectures, group work and field visits. Refresher training was undertaken in all districts. The majority of funds for this project were used to pay for training expenses.

To date the key achievements in this area are:

- 7 trainers in each district received training in syndromic management, MTCT and VCT. These trainers were from district and hospital services
- 454 clinical officers and MCH nurses were trained across five districts, well in excess of the number set by the project.
- 99 people have received refresher training.
- 469 community health workers and TBAs were trained to provide information on STI/HIV/AIDS. This number well exceeds the expected output of 50 CHW and TBAs.
- 420 youth also received training in the 5 districts despite not being identified as a specific target group in the project.
- Health care staff are demonstrating high levels of skills and confidence in their knowledge and skills in syndromic management

3.1.1 Issues

Training in each district, including Training of Trainers, was carried out with input and support from CBOH, National AIDS Council, NGOs such as CARE and World Vision and other donors, particularly USAID. The coordination of this training was undertaken by the DHMT, except for the Training of Trainers that was coordinated by CBOH. The content of these programmes was comprehensive in nature and focused on the range of areas that health care and community workers need to equip them with necessary skills for STI case management and prevention activities.

An amount of A\$247,500 was allocated for training costs over the life of the project. At May 2001, the majority of these funds had been spent, however, there was a small amount remaining for refresher training. Through funding from this project, 1477 people have received training. Broadly, this amounts to a cost of A\$168 per person for training. However this amount would be reduced slightly if refresher courses are undertaken in the next three months. Training is generally considered to be an expensive exercise given that people attending are paid an allowance for travel and accommodation and there are costs associated with meals and venue hire. However the cost effectiveness of this training cannot be determined without some measurement of changes in staff skills and knowledge as the result of receiving training.

Among health care staff at the centres visited during the evaluation, it was clear that those who had received training were more comfortable in their capacity for diagnosis and treatment of STIs

and appeared to be performing better than those who had not received training. Similarly, those who could demonstrate a good knowledge of MTCT had received training. In a small number of centres, messages given by some staff to mothers in relation to risks of transmission of HIV were inaccurate and misleading. These staff had not received training although they were responsible for providing these clinic services.

A key issue in relation to training has been the turnover of staff since the project began and the need for a sustained approach to providing ongoing courses for new staff. While there are a number of trainers located within DHMT staff, there are insufficient resources at the district level to conduct training more regularly. These staff were attempting to assist health centre staff through their regular monitoring and supportive visits, however a more formalised approach to learning would be beneficial.

Two areas that appear to be absent from training programmes were the opportunity for health care workers to consider attitudes, stigma and discrimination associated with HIV/AIDS and the issue of confidentiality and keeping of clinic records. These areas are crucial for reducing the fear associated with dealing with the disease and creating a climate of greater openness around discussing the disease with patients. It was evident that clinic patients were not comfortable to discuss HIV/AIDS issues and that staff were reluctant to raise these issues. Further, staff were not comfortable recording suspected AIDS cases on the basis of clinical manifestations, despite being aware of WHO recommendations and definitions. In some centres these cases were recorded as STIs. These staff stated that they were reluctant to record cases, as ARC could amount to a breach of patient confidentiality. Others felt that it could lead to legal proceedings against them. This reflects a lack of understanding about maintaining confidential patient records and raises the need for procedures to protect information contained in clinic records.

Specific training in voluntary counselling and testing (VCT) was included in the training courses however its use was varied across the centres visited. In the majority of centres, there are trained psychosocial counsellors who provided counselling to patients and their partners. It was less clear how these counsellors had changed their role to provide VCT. A major limitation of VCT was the lack of HIV testing facilities on site and the processes of referral and feedback. There was also a lack of incentives for testing, e.g. access to HIV drugs, HIV/AIDS support groups etc. Where the processes of referral worked well, there were specific VCT trained counsellors co-located with health facilities eg. Kara Counselling service within Chelston Health Centre in Lusaka district.

Training of community health workers and young people has resulted in these groups taking up challenges of working within their neighbourhoods and with their peers. Among youth groups there was a clear difference between those that were trained and untrained. Specifically, the trained youth were more informed, had a greater understanding of their role, were confident in STI/HIV/AIDS prevention messages and were developing increased links with other groups in their districts. In some districts Youth Advisory Boards (YAB) had been established as a forum to share ideas and facilitate discussion on areas important to young people, as well as bring in adults to understand adolescent issues.

A lack of systematic follow-up on training was also evident with some community and youth workers. These people are generally outside of clinic structures and do not receive ongoing monitoring and support around the work that they are doing within the community or health

centre. Also with regular turnover of people working at this level, mostly as volunteers, ongoing training and supervision are essential.

3.2 Component 2 – Implementation of STD/HIV protocols within MCH/FP facilities at hospital and health centres

This component focuses on the implementation of STI screening and treatment services within health facilities and how these services are being integrated with MCH/FP services. National guidelines and protocols for STI management require health facilities to use the syndromic approach and health centres have been provided with flowcharts and procedures for referral where cases do not respond to treatment.

Specifically this component aimed to increase STI screening and treatment for women attending MCH/FP centres, to increase the attendance of their partners for treatment and the number of women attending antenatal centres early in their pregnancy. The design also focused on improving processes for counselling and referral for HIV testing and attempted to capture the impact of these services on rates of HIV/AIDS among clinic populations.

The key achievements to date are:

- 697,299 (63% of childbearing women) were screened across health centres in five districts. This number was higher than the expected target of 557,000 or 50% of childbearing women in those districts.
- 43,923 (6.3%) of women screened were treated. This represents 74.5% of the target set for the project.
- 51% of partners were treated according to national guidelines, slightly exceeding the target of 50%.
- 1,652 or 0.24% of women attending health facilities were referred for HIV testing.
- STI/HIV protocols were being implemented in 102 MCH/FP services across five districts. This exceeds the expected input of 80 MCH/FP services.

3.2.1 Issues

Integrated approach

Health centres in all districts had been using an integrated approach in the provision of basic health services at the community level since 1997. This means that patients receive a range of primary health care services through the one local health centre. Staff working in these health centres are generally trained to be multi-skilled, in order to be able to assess and treat a variety of health issues. Within MCH/FP centres a system for assessing patients is termed “the super-market approach”, meaning that women presenting at these health centres receive a comprehensive assessment of their health needs along with their families, including screening for STIs. The advantages of an integrated approach in MCH/FP centres are that comprehensive services are available every day and women do not need to attend on certain days for special clinics. For example, when a women presents with a sick child, her needs will also be assessed, rather than returning on another day.

All health centres acknowledged that an integrated approach was beneficial, the limitations to this approach working well were physical space, staff knowledge and skills, adequate staff, reporting

and data collection and adequate drugs and supplies. Space to carry out assessments and confidential counselling was clearly inadequate in most health centres.

While all districts acknowledged that the “super-market” approach was being used in their health centres, there was some lack of clarity around the use of this approach in relation to patient booking systems. In Ndola for example, all the five health centres visited had special sessions for antenatal, postnatal, children under 5, while family planning services were available every day. In Kitwe, it was a similar situation. Staffing shortages were reported as the major reason that clinic staff had reverted to special clinic days as they found that this system made it easier to manage their workload.

Some staff stated that the integrated approach did not allow enough time with patients, especially for health education, however it may also be the case that staff have found it difficult to adapt to and adopt this new way of working. DHMT staff in these districts were supportive of health centres working in this way however they also acknowledged the need to provide further assistance to staff around structuring their time and clinic activities to properly integrate these activities and manage their workload.

Syndromic management and STI screening

Overall, health centres are successfully integrating STI case management into MCH/FP services however, in an analysis of data on women treated for STIs comparing information collected between years 1999 and 2000, the number of women treated had dropped by 50%. In a comparison of the number of partners treated for STIs between 1999 and 2000, there was a similar decrease. Between 1999 and 2000, however, the number of women being screened had increased by around 30%. There is no clear explanation for these decreases in rates of treatment however the most positive explanation could be that fewer women and their partners required treatment. However, the lack of STI drugs and RPR kits in health centres was commonly reported and could account for this change. A comparison of data from 2001 will confirm whether this is a trend and it would be useful to conduct further investigations to establish reasons for this decrease.

There has been a similar drop in the number of cases of STIs reported by clinics between 1999 and 2000. Data from 5 districts shows that in 1999 there were 6,157 (21%) cases of genital ulcers and 18,840 (64%) cases of vaginal discharges. Up to September 2000 there were 2,580 (43%) cases of genital ulcers and 2,414(43%) cases of vaginal discharges.

An area that is a serious concern was the limited amount of screening being undertaken for syphilis across all districts. This has been the result of a lack of consistent supply of free RPR kits through the drug supply system. Following the success of the last project in increasing the number of women being screened for syphilis, the drop in numbers receiving screened for syphilis is a real concern. During 1999 screening women for syphilis began to decrease due to inconsistent supply of RPR kits. Since early 2000, most centres have not been able to provide syphilis screening routinely. As a result high numbers of congenital syphilis cases and macerated still births are being reported in all districts. In contrast to the last project, RPR kits were not supplied through this project and districts have not been able to fund these through their drug kits. In Kitwe, Ndola, Chipata and Kabwe, RPR kits were being used for screening however at a cost

to the patient. Those who are unable to afford to pay are denied screening. Costs for RPR testing range from 500 Kwacha in Chipata to 1500 Kwacha in Kitwe.

Treatment for STIs is generally provided through health centres, however there were reports of inconsistent supplies and patients were frequently being given prescriptions and referred to pharmacies to buy medicines when health centres were out of stock. Health Centre staff reported that patients frequently returned untreated because they could not afford to buy the required medicines. Staff also reported that patients often sought treatment elsewhere ie. traditional healers. Some patients were also not attending health centres where they knew drugs were not available. Patients also visited private health institutions more than public clinics. Drugs commonly used to treat STIs at health centres were Benzathine penicillin, Gentamicin, Metronidazole, Doxycycline, Kanamycin, Erythromycin and Tetracycline.

All government clinics were using syndromic management for assessment and treatment of STIs. Staff who had been trained were performing well and appeared to be confident in their capacity for assessment and providing effective treatment. Few patients are referred to higher level services for follow-up as the majority are being successfully treated at the health centre level. In the majority of centres, flow charts were displayed and guidelines were readily available.

In some private clinics and non-project centres, the policy of syndromic management was not being applied appropriately and of particular concern was that in a number of these centres, the drug Co-trimoxazole (Septrin) was still being prescribed contrary to government guidelines, due to its high resistance. The other area of concern was the improvisation of treatment regimes in some private clinics.

Partner follow-up

All districts have achieved success in increasing the rate of partner treatment. More men appear to be using these services and there have been some changes to the way that health centre staff are involving partners in the care of women patients. Specifically men are being encouraged to attend MCH facilities with their partners and to seek treatment themselves through these health centres when necessary. In relation to treatment for STIs, men commonly seek treatment elsewhere, particularly from pharmacies and private clinics, however it was reported that more men are bringing in their partners for treatment. At one clinic, it was reported that men from the local community were also bringing in their other partners for treatment.

In general, women still find it difficult to bring in their partners to the health centre and in districts where partners of women are travelling through, there were lower rates of partner treatment. There is no standard partner notification slip and health centre staff have developed a variety of ways to facilitate partner treatment including letters to partners asking them to come to the clinic, forms advising them to seek treatment with list of centres to attend and counselling sessions for couples. The Neighbourhood Health Committees (NHCs) in some districts were also assisting to promote partner treatment in the community

VCT and HIV/AIDS

Voluntary counselling and testing is a relative new area for health centres. Counselling is commonly practiced in health centres, however counselling for HIV testing has presented a

challenge for clinic staff, specifically, the lack of on-site testing in most health centres, transporting of blood samples and referral of patients, the lack of counsellors in health centres to conduct pre-test HIV counselling and the lack of follow up with test results. VCT is promoted widely as a prevention tool however there are still few centres, mostly in hospitals, and people are required to travel some long distances to be tested.

Overall, there is a low demand for HIV testing. This rate has increased since 1999 however it is still only 0.2% of women who are screened at MCH/FP facilities. The following table shows the increase in numbers referred from MCH/FP facilities in the five districts.

Number of HIV Referrals in 1999 and 2000 across the five project districts.

District	1999	2000
Lusaka	0 (no reporting)	382
Ndola	31	569
Kitwe	3	316
Livingstone	75	183
Chipata	41	52
Total	150	1502

Some of the factors that could have affected this increase are:

- Training of clinic staff may have increased their confidence in discussing HIV with patients
- Training may have improved reporting, counselling and referral procedures
- The presence of VCT counselling services in project districts, especially specialised HIV counselling services such as Sepo Centre in Livingstone, Kara counselling in Lusaka and Hope Humana in Ndola.
- Pre test counselling techniques may have improved
- Health promotion talks to women
- Some distribution of IEC materials

Despite the small increase, these numbers are low for the high prevalence populations that surround health centres in project districts. HIV-related stigma, fear of the disease, a perceived lack of confidentiality around HIV/AIDS, lack of available treatment, shortages of drug supplies and costs of HIV testing may be some of the factors inhibiting women from choosing to know their HIV status.

The number of cases of HIV/AIDS among clinic patients was difficult to determine. Staff in general had difficulty discussing HIV/AIDS with patients and were reluctant to record suspected cases on patients cards. Since HIV testing sites are located away from most primary health centres, people who test positive are generally referred to home care or hospital services and there is little follow up by health centre staff. At one centre in Ndola, two HIV positive women had identified themselves within their communities and to clinic staff. This was not a common scenario and while staff acknowledged that there were women whom they suspected to be HIV positive using the health centre, they found it hard to raise the possibility of HIV infection with these women.

The lack of openness around discussion of HIV/AIDS and difficulty for people to disclose their status does not easily facilitate the integration of HIV/AIDS into MCH/FP services. To a large extent, screening and treatment of HIV infection remains separate from locally based services and the ongoing care of women with HIV/AIDS in the community is being managed by other services. It is unclear how these services link with MCH/FP services locally to provide community care. While STI management has been well integrated into MCH/FP services, the integration of HIV/AIDS does not appear to be as successful. Strategies that could begin to change this include the use of HIV positive women as educators, increasing the skills and capacity of health centre staff to discuss HIV/AIDS concerns beyond simple HIV prevention messages, with their patients and the development of linkages between HIV testing and primary care facilities.

The issue of confidentiality was raised by a number of staff as a barrier to discussing diagnoses of HIV infection with patients. This issue needs to be better understood by health centre staff and training provided in protocols that outline when and how to disclose information in relation to the disease.

Mother to Child Transmission of HIV (MTCT)

Transmission of HIV from mother to child is a new issue that gained great importance within the life of the project. Since the project commenced this has become an important area for training and health promotion by health centre staff. Throughout the visits to centres this issue was repeatedly noted as an area where more information for staff was necessary. In general, staff conveyed information about MTCT to women through weekly health education sessions at the health centres. Mothers were encouraged to test for HIV. This was then followed with counselling sessions for those who requested additional information or who sought an HIV test.

Of concern, was the range of information on MTCT being given to mothers including inaccurate information about the risks of exclusive breastfeeding and bottle-feeding. The majority of health centres were promoting choice around breastfeeding and were using protocols for reducing infection during delivery, however staff did not seem to have a clear approach to assisting mothers where their choice was not to breastfeed. There was also no IEC material available in centres that would be useful to reinforce these messages.

The lack of drugs like nevarapine to prevent transmission to babies and improve the quality of life of the mothers pose a very significant barrier to the success of MTCT initiatives.

Data and Reporting

Reporting by health centres to districts on data collected has been consistent through the life of the project. The design specified a number of performance indicators on which districts had to report quarterly. This information did not however cover the extent of information that may have been useful to measure some of the changes through this project. For example, the number of women with clinical symptoms of HIV/AIDS; information on common STIs, congenital syphilis, macerated still births; number of youth, especially young women, referred for STI screening and HIV testing; number of women attending ANC in first trimester and number of women screened who tested positive for STIs or HIV/AIDS.

In all project districts, health centre staff were constrained by the number of forms that they were required to complete in each quarter. In some districts, staff were required to complete 5 different forms. These reporting formats arose from the number of funded activities through donors as well as information for CBOH's Health Management Information System (HMIS). Much of the information on which health centres had to report was duplicative and this process should be streamlined.

There was also a lack of consistent reporting on HIV positive results within and across districts. Information from private clinics is not forwarded to districts and government health centres are not recording HIV/AIDS cases based on WHO case definition guidelines for AIDS related conditions (ARC). Within the health centres it is also difficult to identify the range of STIs being identified and treated. STIs are recorded and aggregated in HMIS data, so short of pulling out and going through individual clinic registers, this information in its current form has limited value.

Little information existed on HIV/AIDS to provide baseline data to assess changes through the project. In 1998 sentinel surveillance surveys were undertaken by CBoH throughout antenatal clinics and results of these surveys have provided up to date prevalence data for districts. Follow-up sentinel surveys are needed to measure changes. Clinic staff need to develop ways to acknowledge HIV/AIDS in their reports to districts and staff at both health centre and district level need to understand the usefulness of this information for planning and obtaining more resources for prevention and care.

Drugs and medical supplies

Inconsistent supply of STI drugs, gloves, needles and syringes and lack of RPR kits was commonly expressed as a major issue of concern across all districts. It was clear that drug kit supply to districts was inadequate to meet the demand for these STI treatments and RPR kits. Both clinic staff and community representatives stated that the lack of drug treatments and clinic supplies acted as a disincentive to seek treatment through health centres. Systems of ordering and distribution of supplies need to be further examined, however, some centres reported that they were only ordering what they knew was in stock and would go without certain supplies for long periods because these were not available in the district. While there were systems in place for regular ordering of supplies, there did not appear to be clear mechanisms for monitoring shortages and sourcing alternative supplies. In order to manage the burden of drug costs and supply, some districts had begun to charge user fees for certain treatments of STIs, despite national policy that specifies all STI treatment should be provided free of charge.

Youth Friendly Health Services (YFHS)

Youth Friendly Health Services were evident in all health centres visited. Although the type and extent of these services varied, the integration of these services in MCH/FP facilities had increased the sensitivity of staff towards young people and set up procedures for youth to access these services. Some of the ways that health centres have strengthened these activities are: establishment of Youth Corners in each centre; allowing youth to be seen as soon as they present rather than wait in the queue; appointing focal persons in health centres for young people to contact; the integration of youth into other clinic activities ie. community prevention efforts

around cholera, malaria, child health; and assisting youth with action plans. Where youth are receiving support from health centre staff they appear to be enthusiastic, more informed, knowledgeable and confident in their activities.

3.3 Component 3 – Social Mobilisation and development of appropriate IEC materials on STD/HIV/AIDS for women attending antenatal, postnatal and family planning clinics, their partners and the community

This component aimed to increase the involvement and participation of communities in developing a response to STI/HIV/AIDS within their communities. The design of the component focused on the development of IEC strategies including: information on STIs/HIV/AIDS; information on availability of services; messages on HIV counselling and testing, MTCT and HIV; and, materials for improving health worker skills in STI case management.

Key achievements to date are:

- Booklets, leaflets and posters on STI/HIV/AIDS have been designed and will be printed and distributed prior to the completion of the project.
- A number of radio programs have been broadcast in Kitwe, Chipata and Lusaka.
- In Kitwe, 20 youths participated in 50 radio programs using role-plays, interviews and discussions informing the public about the availability of Youth Friendly Health Services.
- The number of drama performances has well exceeded the target. Each district has developed programs of community drama performances. These have been conducted in schools, markets, churches and other community events.
- Youth groups, NHCs and mother support groups have been active in community IEC activities.
- Ndola held an intra-district youth festival where drama and other activities were performed.
- Drama groups have supported health centre staff on their outreach activities within the community.
- 4000 canvas bags to promote early visits to antenatal clinics have been distributed by health centres.

3.3.1 Issues

Communities appear to be actively involved in STI/HIV/AIDS prevention efforts and are assisting in health centre activities through a number of ways: young people through youth services and peer education activities; women through NHCs and mothers support groups; and, community health workers and traditional birth attendants assisting with care and support in the home and in the provision of condoms and other family planning needs.

Community participation

Under the health reforms, Neighbourhood Health Committees (NHCs) have been established to facilitate increased involvement and participation of communities in health sector activities. The Neighbourhood Health Committee is a group of people selected on the basis of trust by the community. They are often composed of men and women who live and know the area and are based on the household. They spearhead the development of community based activities in the field of health (or other sectors like agriculture etc.) for the people in the area they live. The

NHCs are supported and strengthened in their role to monitor and support local health services by the HC Committee and the District Health Office.

Within communities, NHCs are providing leadership and initiative to identify local issues and mobilise their communities to take action to prevent disease. In addition to HIV/AIDS prevention their activities include reducing cholera outbreaks through encouraging home purification of water using the socially marketed Clorin (chlorine) and malaria through the use of bednets. NHCs are also active in distribution of condoms and family planning consumables, undertake health education talks and assist with tuberculosis DOTS program within homes. These committees also assisted with coordination of health centre prevention activities, including the use of community health workers, growth monitors and traditional birth attendants.

This Project was also assisted in four districts by USAID's Zambia Integrated Health Programme (ZIHP), a project that has provided technical assistance and training to strengthen districts and NHCs capacity to plan and implement integrated programmes.

It is clear that there are strong partnerships between health centres and NHCs. NHCs work closely with health centres in each district through regular monthly meetings where health centre and community needs are discussed. Representatives from NHCs are also involved in management decisions at health centre level. NHCs have input to health centre planning activities as well as to the action plans of each district. At the community level they maintain a link between health centres and the communities they serve as well as a level of accountability to these groups. For example, one NHC in Livingstone had surveyed their communities' level of satisfaction with clinic services. In this situation, the communities were highly satisfied, however, there were processes in place for discussion of local concerns and NHCs reported that health centre staff were responsive to these concerns.

Ways to assess community participation in health centre activities has been a challenge for DHMTs and donor organisations. Activities such as representation on health centre committees, the inclusion of communities in planning and evaluating health centre services, and working in partnership with local communities are all elements of good practice in relation to community participation and involvement. The level of satisfaction among community groups in relation to their sense of involvement and their assessment of the responsiveness of health centre staff to local concerns are also ways to measure these processes.

Youth

Although youth were not identified as a specific target group for this project, it is clear that they are a key group using health centre services and have played an important role in community mobilisation activities. Youth have been included in training courses and are developing skills to identify and discuss STI/HIV/AIDS and to conduct prevention activities.

Most of these young people have been trained by different organisations as peer educators and take this role very seriously. Their community-based activities include talking with young people about STI/HIV/AIDS and referring them to health staff for treatment, distributing condoms, designing and conducting drama sessions within communities. While they receive some support

from district and health centre staff, they are largely undertaking their activities without financial support or supervision.

Among young girls, high rates of teenage pregnancies are reported and there is a lack of information and referral for terminations, despite provisions within Zambian law. Dissemination of prevention messages also varied across youth groups. Broadly, there were two types of peer educators, those who promoted abstinence and those who promoted the use of condoms. While a range of messages is important for young people, the dissemination of accurate information and assisting young people to make the right choices in relation to sexual behaviour should be the most important focus for prevention efforts.

Among peer educators, there is a high rate of turnover and the need for refresher and ongoing training for these groups is crucial to ensure that they have up to date skills and feel knowledgeable about the information they are providing. The issue of incentives was frequently raised by youth and health centre staff. Young people have few resources and found it difficult to sustain their activities over time without resources to conduct their activities in the community. Access to transport, a lack of IEC materials and equipment to use and the regular supply of condoms to distribute were all cited as constraints to sustaining their activities.

One youth group in Lusaka, had collected donations through their community presentations and had invested this money in a bank account, acknowledging that this was one way to sustain their activities. Income generation projects were identified by young people as an important way to sustain their motivation and interest in their work and to provide an incentive for others to join in. Some of the opportunities identified were funds collected through sale of condoms, showing of videos and drama events and setting up tuckshops in communities.

In some districts, intra-district meetings, District Youth Advisory Boards, were being held and these were considered to be valuable to those who attended. These meetings provided an opportunity to discuss activities and learn from other young people and in some case, the opportunity for youth to express their views on district health policies. Similarly, youth exchange visits were also seen as useful.

IEC

There was a lack of information material on HIV/AIDS, VCT and MTCT at all centres visited, while a small number of centres had had some supplies of leaflets on STIs. Most centres had posters on STIs and HIV/AIDS displayed however staff had not received any material for distribution for some time. Both health centre staff and community health workers thought that these materials would assist them in their community prevention activities. Youth groups expressed concern about the lack of local material and requested assistance to develop more relevant material for their peers.

Through this project, funds have been earmarked for the development and printing of IEC materials. To date the design and pre-testing of pamphlets and posters on MTCT have been completed. These delays have been due to pre-testing processes and the time taken by the IEC Sub-Committee of the National AIDS Council to approve the material. It is expected that the

number of pamphlets to be printed and distributed prior to the end of the project will well exceed the target of 5000.

Reporting by health centres and districts on IEC and community activities has been inconsistent. There has also been a lack of information on the extent of reach and type of audiences that these activities have been targeting, however this information was difficult for community health workers to collect. While most of these community-based activities are undertaken according to community action plans, there appear to be few formalised systems in operation that could assist to monitor and record outcomes from these events. Clearly the design underestimated the number and type of community-based events that could have been undertaken, as all districts have surpassed these expectations.

Condoms

The supply of free public sector condoms was inconsistent across all districts in both public and private health centres. In particular, in Livingstone and Lusaka there were no condoms available in the health centres visited. This lack of condoms appears to be due to shortage of condoms at a district level and it is of concern that these shortages exist. Demand at all centres and within surrounding communities was high, particularly among the youth. A small number of centres were distributing social marketed condoms, at a cost of 250 Kwacha in some areas. Innovative ways of linking public and private health practitioners to the socially marketed condoms should be vigorously pursued, so that there are always condoms available within health centres.

NHCs are actively promoting use of condoms and their acceptability as offering dual protection from STI/HIV/AIDS and unwanted pregnancies. In a number of communities, women are using the female condom and it was reported that some people are using the male and female condom simultaneously. This practice is known to increase the risks of breakage, however it does reflect the level of concern that some people have for their protection. Community educators need to be informed of the dangers of this practice and given ways to assist people with correct procedures in using condoms.

3.4 Component 4 Monitoring and Evaluation

This component sets out the reporting, monitoring and supervisory requirements for DHMT, UNICEF Zambia and UNICEF Australia in line with contractual funding requirements with AusAID.

Key achievements to date have been:

- Formats for collecting data for performance indicators were developed
- DHMT staff are providing quarterly monitoring and supervisory visits to all health centres
- Reports on health centre activities in relation to this project had to be submitted quarterly
- Progress reports from UNICEF Zambia to UNICEF Australia have been submitted quarterly.
- UNICEF Zambia has undertaken field monitoring visits quarterly since 1999
- 3 Inter-district project review meetings have been held
- UNICEF Australia have undertaken two field monitoring trips in 1999 and 2000
- UNICEF Australia has submitted annual reports to AusAID

- Final project evaluation was completed in May 2001.

3.4.1 Issues

A key achievement has been the strong and consistent monitoring and supervisory arrangements between DHMTs and health centres. Each quarter, a team of DHMT staff, with a mix of skills, visit each health centre to undertake a comprehensive assessment. In general, health centre staff found these visits supportive and could use these visits to identify and resolve problems. These visits usually take one day and some staff stated that this was too long and was disruptive to their routines. However, most staff thought of these visits as useful and wanted more time with supervisory staff to discuss issues, receive updates and on-the-job training in areas where they felt their skills needed upgrading. In Livingstone, focal points had been established within DHMT for each health centre. This has enabled staff at these centres to more readily contact a person in DHMT when needed and for DHMT to visit their focal health centres more frequently.

An important area for DHMT staff is to assist and monitor centre staff to manage and record cases of HIV/AIDS. Clearly staff need more assistance in this area and apart from additional training, support through regular processes of supervision could assist this to occur more readily.

Some of the mechanisms to increase contact between health centre staff within districts have been training activities and other events, however ways to increase the opportunities for sharing information and local initiatives should be facilitated. Other suggestions included the rotation of experienced nursing staff around health centres to assist in training more staff across the districts.

Whereas DHMTs are providing good support to health centres in their districts, they were not able to provide the same level of monitoring of private clinics. Staff working in these facilities lacked up to date information and were not linked with other clinicians or health care staff for information or referral purposes. At district level there was also a lack of forums for doctors, nurses and other health care staff to discuss clinical concerns. A particular area of concern being the information resources being available to private practitioners.

4.0 Factors affecting performance

4.1 Project management

Funding for the project was forwarded in June of each year by AusAID to UNICEF Australia following receipt of an annual report. This funding was then transferred to UNICEF Zambia, minus a small amount to cover UNICEF Australia's costs for project management. UNICEF Zambia then forwarded funds to CBoH based on budgets submitted by project districts for their activities under this project. While these funds were allocated for project activities they were placed in the district "basket" of funding for integrated health care services. These funds were accounted for through reports from districts of budgeted activities being undertaken.

Despite the complexity of "basket" funding approach at the central and district levels it appears that funds were used appropriately for project activities and that the mechanisms for monitoring and accountability worked to ensure that these activities were conducted in line with the project

components. It also appears to have given districts much greater involvement and accountability for how funds are spent in line with their priorities.

UNICEF Zambia was responsible for liaising with DHMT staff and monitoring project activities. Monitoring visits occurred quarterly where possible and inter-district review meetings were held six monthly in the 2nd and 3rd year. UNICEF Australia also monitored the project through annual visits. These supervisory processes and meetings provided the opportunity to raise and resolve a range of issues. Many of these issues related to lack of drugs and supplies and difficulties around staffing and reporting.

A number of recommendations arising from these meetings and visits are listed in the Second Progress report. The same issues have again been identified during this evaluation. While many of these are systemic problems, there is little evidence that subsequent visits and meetings have focused on developing solutions at the national or local level and developing ways to improve the sustainability of this project. The monitoring visits however appear to have strengthened aspects of service delivery in some districts and approach to STI screening.

The project provided funding for personnel through UNICEF Zambia. These positions were for a full time Project Coordinator in years 2 and 3 and for a part time IEC Coordinator for 3 years. The responsibilities of Project Coordinator were to support project implementation, facilitate training, support the development of field research on HIV, ensure linkages between UNICEF and donor assisted projects and develop and implement the monitoring and evaluation plan. The IEC Coordinator was responsible for development, implementation and monitoring of an IEC strategy for HIV/AIDS at health facilities and within the community.

It is clear that the project has benefited from having a full time coordinator in the UNICEF office in Zambia. This position has maintained links directly with the districts, facilitated meetings and assisted with design and implementation of activities. It has also been the point of contact for UNICEF Australia and through this relationship reporting and feedback has been more timely and relevant.

There was no evidence of the IEC position in the office in Zambia. While material and a strategy have been developed there is no one person occupying this role. It appears that these funds have been spent on health section staff and their work on developing IEC materials.

An area that could have been further developed was operational and field research that was expected to be undertaken through the project, although specific funds were not made available to do this. There were funds allocated for a baseline survey, presumably to assist in the development of IEC materials, however there was no evidence that this survey was undertaken by the project. The conduct of operational research in this project would have added value to the activities undertaken, especially identifying some of barriers to access for women and their partners to STI/HIV/AIDS services and using this information to design new ways to reach target groups.

Cost effectiveness of project

Estimates of cost effectiveness of this project have been made through a broad assessment of expenditure against project outcomes. From the data available up to last quarter 2000, 697,299 women were screened for STIs. Funds paid to UNICEF Zambia for project activities have

amounted to A\$981,570 over the three-year period. The direct cost of screening per client was therefore assessed as A\$1.48 or US\$0.72. In relation to treatment for STIs, the cost to treat each woman was A\$23.54 or US\$11.50. These costs are likely to be reduced with updated information on numbers of women screened and treated in project districts since October 2000. However, these costs do not take into account the administrative expenses associated with managing the project and recurrent health centre expenditure provided by CBOH and DHMT.

The assessment of the cost effectiveness of this project was limited by a number of factors: the time needed to analyse project records in Lusaka and lack of cost data collected by health centres and DHMT. There was also no data being collected on health outcomes and prevention strategies at health centre level eg. no. of people receiving VCT, no. of cases of HIV/AIDS, no. of condoms distributed. Information to support these activities may have provided some quantitative information to assist in assessing the effectiveness of the project.

The objectives of the project were to provide access for women to STD and HIV/AIDS services and improve quality of service provision, While the cost of providing access to screening may be cost effective at around US\$0.72 per client, the lack of data available to measure the impact of these services on health outcomes made it difficult to provide an overall assessment of this aspect of the project.

4.2 Institutional issues

Health reforms

In 1991 the new Zambian government embarked on radical health reforms to provide equity of access to cost effective quality health care through the principles of leadership, accountability and partnership. During 1996 the newly created Central Board of Health (CBOH) took up the executive role in health service delivery. The vertical programmes, formerly run by the Ministry of Health such as MCH/FP and the National AIDS Programme, were fully integrated into the systems and operations of the CBOH from the beginning of 1997.

The health reforms focused on decentralising the health delivery system through organisational and institutional restructuring. The major thrust of the health reforms was the devolution of managerial autonomy to autonomous health boards for planning, personnel management, service delivery, funding, resource allocation and revenue generation. This involved the establishment of District Health Management Boards (DHMB) that were sub-contracted by the CBOH. CBOH itself would be contracted by Ministry of Health (MOH) to deliver health services in the country. The DHMBs would then employ District Health Management Teams (DHMTs) who would carry out health services. The system was based on the British National Health Services (NHS) and aimed to bring, among other things, some private sector incentives and management styles through this managed market system.^{8 9 10}

⁸ Cassels A, Janovsky K. Health Reforms in Ghana and Zambia: Commonalities and contrasts. WHO, Geneva 1996.

⁹ Collins C. *Management and Organisation of Developing Health Systems*. Oxford Medical Publications, Oxford 1994.

Currently in Zambia, 72 districts and 20 hospital management boards are operational. The district health boards submit their annual plans and provide the CBOH with quarterly progress reports and financial accounts of disbursement against budgets. The boards are financed from a national basket in which funds of the government of Zambia and its collaborating partners are pooled.

Over the past years, the MOH and CBOH have emphasised the integration of efforts to support the delivery of cost-effective interventions in an integrated manner. The emphasis on integration has led to significant innovations and the approach is firmly supported by all stakeholders. However these have also been significant constraints with the implementation of these reforms. First, direct technical support for programmes came to an end, without any alternatives being put in place. Second, staff transfers or delinkage whereby MOH delinked all civil servants from the Public Services Commission, resulted in shortages of staff, loss of staff skills and knowledge in many institutions. Other serious effects of the decentralisation process has been the interruption of drug supply, disruption of leadership, a loss of donor support for programmes, and low staff morale due to voluntary separation.

Problems that have surfaced through this process were to do with the environment in which the DHMTs were expected to operate. DHMTs were supposed to partner with other government departments within the districts that were still centrally run. This has made a multi-sectoral approach very difficult as other departments have had to wait for Lusaka or the province to make decisions.

Health service delivery

The health service delivery system is coordinated at four levels: at the national level through the CBoH Management Board; at 2nd and 3rd level referral hospitals through hospital management boards; at district level through the district health boards; and, at the community level by the Health Centre Committees and the Neighbourhood Health Committees.

These structures appear to have supported the project through facilitating community participation in health centre activities and through established planning, monitoring and supervisory mechanisms as well as processes for referral.

Accessibility to health services was also a key element of the reforms. Currently 66% of Zambian households are within 5km of a health facility, 24% between 6 and 15km, and 10% live more than 15km from a facility.¹¹ Health centres are focused on understanding the needs of their catchment populations and through this project there has been a strong effort to increase the accessibility of services to these populations through outreach activities, providing treatment in people's homes and providing assistance to bring people into health centres.

Coordination of STI/HIV/AIDS services

Under the reform system, the National AIDS council and secretariat were established in 2000 to coordinate the management of HIV/AIDS/STI control programmes in the country. This body

¹⁰ Kasonde JM, Martin JD (eds). *Experiences with Primary Health Care in Zambia*. WHO, Geneva 1994.

¹¹ Central Statistics 1996.

provides the overall leadership and direction for these programmes through National HIV/AIDS /STI strategic framework.

The National AIDS Council also supports a number of technical sub-committees, such as MTCT, IEC, STD and VCT. At the national level these sub-committees have played an important role in supporting the project through the development of screening and training programmes. However they have also been a constraint to the project through the lack of meetings of some committees and delays in pre-testing and approval of IEC material.

At the district levels, the formation of HIV/AIDS task forces provides the opportunity for local issues to be discussed and for donor agencies, NGOs and government organizations to identify areas for collaboration and coordination.

Partnerships

Co-operating partners (both bilateral and multi-lateral) have been supporting Zambia over the period of the reforms with political, financial and technical support at the national and district levels.

Data and information

Health Management Information System (HMIS) and Financial Administration Management System (FAMS) together provide the bulk of the information not only to assess the functioning of the health services, but also the progress of the reforms itself. The information generated at the health centre level is transmitted to CBOH through the district and provincial levels using the aggregated HMIS forms. However, because information on STIs is aggregated it was difficult to determine any change in trends of patterns of STIs across districts.

The CBOH Monitoring and Evaluation unit is further involved in the establishment of an effective system of dissemination of information through available channels in the health sector - meetings, workshops, reports, revived Epidemiological Bulletin, Internet web site, etc. and through collaboration with relevant external organisations. The introduction and maintenance of a reliable system of data capturing, analysis and communication using up-to-date electronic tools or systems, will remain an important activity and will be a necessary tool for planning and delivery of services into the future.

Drug supply

Systems for drug supply have been developed through to the community level. At central level funding for drug kits are allocated based on essential requirements of health services at all levels. Despite efforts to secure funding for these supplies, there remain severe shortages in basic treatments for STIs. These shortages have critically hampered the efforts of health care staff to conduct comprehensive screening programmes and provide treatment. This situation has also undermined the confidence of the community in their health care services. Most importantly, these shortages are resulting in a reversal of gains made in STI control in previous years, especially among project districts.

Efforts by donors to improve this situation have resulted in the proposal for a parallel supply system that will ensure more efficient procurement and distribution of supplies, bypassing the government system. This system would provide for additional funding and capacity building for

CBOH and in turn districts to procure supplies. It is anticipated that over time, drug budgets would be decentralised through the basket mechanism for demand-driven procurement and possible competition. It remains to be seen whether this initiative will improve the current situation however it does offer the potential to strengthen supply systems.

4.3 Gender, social and cultural issues

Despite the high prevalence of HIV/AIDS in Zambia, this is still a very stigmatised disease. Within communities, people living with HIV/AIDS remain hidden and are fearful of disclosing their status. In health centres, staff are unable to discuss these issues openly with patients and referral rates for HIV testing remain very low. It is well understood that stigma and perceived discrimination in health care settings prevent people from accessing testing and treatment services, resulting in further transmission of HIV and lack of appropriate care. While knowledge about HIV/AIDS is high in these communities, and most people know of someone who has died from AIDS, communities are still struggling to find ways to create a climate that is supportive of those living with HIV/AIDS. The use of HIV positive educators is one initiative being used in some districts. This provides a “human face” to HIV that can break down some of the fears and stigma that people have about the disease.

Cultural expectations around breastfeeding also influence the ability of health care workers to discuss and change attitudes and behaviour among women around alternative methods of infant feeding. It is reported that women who do not breastfeed are stigmatised within their communities and this could signal their HIV status to others in the community. Mothers support groups have a role to play in supporting women who choose alternative feeding options and find ways to make these choices more acceptable within communities. Men also need to be encouraged to be involved in the decision around infant feeding and provide support to their partners.

Cultural inhibitions around talking about sex may play a role in stigma associated with HIV/AIDS. In general sexual issues are not easily discussed between men and women or between generations. It is not considered appropriate for parents to talk to their children about sexual matters and young people receive most of their guidance about sex from their peers or an “aunty”. Additionally, the church plays a strong role in influencing the types of messages about sex that get discussed in communities and through prevention programmes.

Gender roles and their impact have been addressed through this project. Although women have been the primary group targeted through health centre services, there has been a concerted effort to increase the involvement of men in treatment, counselling and reproductive health activities. This has occurred through an emphasis on partner contact at health centres and through community mobilisation activities that have involved men in prevention initiatives.

While men appear to be playing an increased role in reproductive, STI/HIV/AIDS activities, women are still seen as having the major responsibility for reproductive and sexual health. Women are frequently blamed for sexually transmitted infections and violence towards women in relation to this issue is reported to be relatively common, but not often discussed. Women still find it difficult to bring their partners to health centres for treatment whereas men are able to do this more easily. Poverty and the impact of HIV/AIDS within communities are also increasing the vulnerability of women in terms of their personal and financial security. Lack of access to money

to pay for tests and treatment, limited capacity to discuss reproductive and sexual health issues and fear of partner response may be among the factors that inhibit women from accessing STI screening and HIV testing.

Health centres have attempted to improve the dialogue between men and women around sexual issues through counselling services however there has been only limited progress to date. Within the communities there is also reluctance to openly discuss sexual issues between men and women, however, among young women and men there also appears to be increased dialogue around sexual behaviour. Those working in youth services reported increased confidence in negotiating sexual relations and attributed this to their training and responsibilities as peer educators. The use of female condom among women suggests that women in some communities are taking greater responsibility for self-protection and may be more confident in negotiating sexual relations. Similarly, the demand for male condoms is high and around some centres, men are taking responsibility to ensure that their sexual partners are receiving treatment

At the community level, women play an active role on NHCs. Among the NHCs consulted, there were equal numbers of women and men on the committees and women were in executive positions although not often as Chairperson. While it is a constitutional requirement that NHCs have equal numbers of men and women represented, it was evident through the consultations that women were actively involved and were a vocal group on these committees.

In training programmes although women were the predominant group among health care workers, men also received training. The project however did not collect data disaggregated by gender. The majority of data collected related to women using services and this reflected the information at health centres. Data on men utilising MCH/FP services would have provided a valuable insight into gender-related activities at health centres.

At the broader level, there is a lack of information collected on health issues relating to gender. The HMIS does not disaggregate data on gender, so it is difficult to establish differences in patterns of infection between men and women and to get useful information for research, planning and programme development.

4.4 Technical issues

Training

Health centre staff have received training in syndromic management of STIs. However, training in VCT and MTCT was not as widespread. As VCT and MTCT are relatively new services, this area requires a lot of advocacy, social mobilisation and staff training. Where this training has been undertaken it is more around awareness raising than in actual implementation. Trained members of staff had adequate knowledge of their subject matter as assessed by their knowledge of disease syndromes and drug regimes. This was apparent when contrasted with non-project sites, where knowledge of STIs was not as good and practitioners still used dated drugs and sometimes those that are not even active against STIs.

There were also concern over the issue of breast-feeding in the light of mother to child transmission of HIV and the proven benefits (in the absence of HIV) of exclusive breastfeeding.

This issue needs to be clarified so that there is no room for ambiguity in the information being disseminated by health care workers. There is a need to revise the training materials for STI training to include VCT and MTCT.

It was noted that follow-up refresher courses to keep the practitioners updated had not been done. These courses are necessary to address gaps that are revealed through the implementation process as well as to keep practitioners abreast of latest developments in their field.

Peer education

Peer education is a common approach used by young people and other community groups to undertake community education and is broadly recognised as a way to influence behaviour change through increasing the knowledge and behaviour change among peer networks. The concept of peer is usually understood to be a person who is at the same level, age and who ranks equally with the other person. Peer educators are generally people working as volunteers in their communities. It is generally accepted that peer education programmes require substantial resources in training and support of peer educators for their sustainability.

Despite the enthusiasm and commitment of many of these young people to work as peer educators there were few programs that provided training and supervision of the activities of these groups. These peer educators were trained by various bodies, therefore the standardisation of the training of peer educators is vital in order to convey same or similar messages. This should be supported by a system of refresher courses. There is clearly a need for more resources to be put towards peer education programmes and training to focus on skills of communication, behaviour change strategies as well as information on STI/HIV/AIDS.

A small number of youth services were receiving support and training however there was little evidence of ongoing involvement and support from specific organisations with these groups. It was common for youth services to report high turnover of volunteers and a lack of direction in their activities. The issue of incentives was raised constantly as a way of sustaining volunteer activity. It would be ideal to contrast the use of untrained peer educators and repeated training cycles against the cost of appropriate incentives.

Community Participation:

Community mobilisation is an essential component of health promotion. The involvement of community members in planning, decision-making and implementation of health care and prevention services not only strengthens the quality, relevance and responsiveness of these services but the capacity of the community to sustain behaviour changes.

Communities are actively involved in the planning and delivery of health services, especially through community based distributors (CBDs) who provide reproductive health commodities, DOTS management etc. This involvement appear to be enhancing the range and quality of services being provided by health centres. The use of volunteer support groups (mother support groups, people living with HIV/AIDS, peer educators) is evidence of community participation in conjunction with health centres. The areas that would benefit from further exploration are community-based counsellors, peer educators and the use of people living with HIV/AIDS as educators.

VCT

As described earlier, counselling programs require more emphasis on quality of counselling practice and skills of health centre staff to provide basic counselling for women and their partners. More recently there has been a focus on VCT and an expectation that this should be provided at health centres. However VCT is a comprehensive approach for entry to HIV prevention and care programmes. To be effective it requires services to be much more accessible than was evident in the project districts. It also requires a number of elements of prevention and care programmes to work together – community mobilisation and support, protocols for counselling and referral, networks of support and community care services and climate of support and acceptance of people living with HIV/AIDS.

MTCT

It was evident that mother to child transmission of HIV was an area needing much more focus and technical support through training and supervision of health centre staff. These staff needed more knowledge and assistance to provide clearer messages to women specifically in relation to breastfeeding. Messages on walls of health centres promoting exclusive breastfeeding reflected the confusion being expressed, however cultural practices may also contribute to a reluctance to change these messages.

There also appears to be a lack of understanding of issues inhibiting women from seeking HIV testing and changing patterns of breastfeeding behaviour. While comprehensive packages that offer women treatment, nutrition and supportive care may be an incentive to change behaviour and encourage more women to be tested, it seems that there are a myriad of factors that need to be understood prior to development of further interventions in this area.

Research

A key area that may have limited the outcomes of some of the initiatives in this project has been the lack of operational research. The outcomes of this project have highlighted a number of areas that need to be better understood, eg. Issues of quality of screening and impact of lack of treatments and RPR kits on STI rates; reluctance of women to seek testing; sexual behaviour and risk practices among young people. Information obtained through this research would be useful to develop appropriate educational interventions and improve clinical practices.

4.5 Sustainability

The major issues that can affect the sustainability of the activities undertaken through this project are:

- Regular supplies of STI drugs, RPR kits, IEC materials and other consumables
- Capacity of DHMT to provide training and ongoing supervision
- Commitment of communities to maintain an involvement in prevention activities
- Support for young people to sustain their peer education efforts
- Communication and coordination between donors and government agencies.

This project is due to end in September 2001 and it is expected that a number of these activities will be continued through health centres, albeit in a reduced way. Training programmes have

used a large proportion of the funding available through this project and DHMTs have limited funds available to continue this training. Further, training programmes need to become more comprehensive in terms of their content, specifically to include attitudes and HIV-related stigma and increase the components on MTCT and VCT. Training of trainers may be one strategy to make best use of limited resources, however it is useless without sufficient resources for these trainers to then train other health care workers. Refresher courses are also necessary for updating those trained and for ongoing development of clinic staff.

Regular and consistent supplies of STI drugs, RPR kits, condoms and other consumables for use in health centres are essential to encourage and sustain the quality of STI screening. Health centre and DHMT staff were clearly discouraged by the lack of availability of these supplies and the futility of offering screening when treatments were not available. It was also reported that patients were reluctant to attend health centres for treatment because of the lack of drugs and supplies. Some districts had attempted to introduce user fees to cover their costs to provide drugs however these costs were still too high to ensure that all women were screened for STIs.

The use of volunteers among communities and youth groups may be a cost effective strategy however for this to be a sustainable approach, systems to resource, support and motivate these people need to be developed. Training programs for community workers and processes for community involvement in health centre activities have increased commitment and responsibility among community groups however, without resources and support to do their work, these highly motivated people will lose interest and withdraw from these activities. With increasing poverty in communities and its impact on households, expecting people to use their own resources to undertake prevention activities is not sustainable. To maintain the level of commitment and interest, some form of incentive needs to be considered for community and volunteer groups.

Donor responses to STI/HIV/AIDS prevention efforts appear to have been well coordinated at district level. Communication between all players has also been an important factor in getting things done at the community level and tackling local issues. The development of district HIV/AIDS Taskforces and youth advisory groups have also been useful vehicles for improving donor and government responses.

5.0 Conclusions and recommendations

5.1 Conclusion

Overall this Project has achieved some success in integrating STI/HIV/AIDS services to MCH/FP facilities. Primarily this is evident through the screening procedures that have been established in health centres and through practices of clinic staff. It was also evident that health centre staff had skills and confidence to conduct screening using STI syndromic management and that their knowledge and skills had been increased through training, support and supervision. Staff have also done the best with what they have had available to use for screening and treatment. Clearly, there has been an increase in the number of women being screened at MCH/FP facilities however there appears to be a trend of fewer women (and their partners) being treated for STIs, despite evidence of increasing number of STIs in the community. The widespread lack of free drugs and reagents is likely to be the most significant reason for this decrease as fewer people are able to receive treatment through health centres or are referred elsewhere.

It was also a significant concern that following the increase in screening rates for syphilis in the previous project, these rates have now dropped and staff appear to be discouraged about the quality and effectiveness of the service that they can provide. There also appears to be a temporal association between when the supplies from the previous project ran out and the increase in numbers of babies being seen in these health centres with congenital syphilis. While it is acknowledged that supply of drugs and reagents through this current project was not possible, there needed to be much closer monitoring of the impact of this on outcomes for women and their children, and urgent efforts made to rectify this situation.

While STI case management was being implemented with some success in most health centres, HIV/AIDS services require further development. Specifically, voluntary counselling and testing and MTCT services need to be increased and staff supported through training and supervision to provide accurate information and establish appropriate referral processes. Staff need further skills in counselling and VCT sites should be expanded and linked more closely with MCH/FP facilities. MTCT services need to be expanded to include a comprehensive package of care for mothers, however, this package would need to be carefully structured according to the staff skills and resources available through health centres and districts.

Demand for VCT is slowly increasing however it is limited by staff reluctance to raise and discuss HIV/AIDS issues with clients. A climate of fear and stigma still exists within communities in relation to HIV/AIDS, although there are many efforts to combat discriminatory practices. Health care and community workers need much more training on attitudes and practices, including confidentiality, related to HIV/AIDS and clear procedures for referral and ongoing community care, to begin to truly address HIV/AIDS within these facilities.

There has been a strong community mobilisation effort through the project and the range of prevention activities that have been implemented is impressive, as is the enthusiasm and commitment from community members. The lack of IEC materials and the inconsistent supplies of condoms have made these efforts more difficult and potentially reduce the impact of these activities within communities. Finding ways to sustain these efforts is essential as peer-led activities and community involvement can create long term changes in people's behaviour.

5.2 Lessons learned

The following have been the key lessons learnt through this project:

- Training and regular supervisory practices contribute to integration of STI/HIV/AIDS into MCH/FP services.
- Training on attitudes and stigma associated with HIV/AIDS is necessary to assist health staff address HIV/AIDS management adequately.
- The availability of STI drugs and RPR test kits enable quality care and treatment. Erratic availability leads to a reversal of project achievements. When drugs and reagents were available health care staff felt more comfortable and confident in conducting comprehensive screening.
- The reduction of STI referrals to OPDs is due to effective STI management and treatment in health centres.
- The involvement and participation of communities and youth in health centre activities and development of action plans can lead to empowerment.
- Neighbourhood Health Committees and mother support groups can contribute to breaking the silence on sexual issues across generations and between men and women.
- Health information talks on MTCT only, may not be enough to encourage women to find out their HIV status. Other incentives to motivate women to test, may include comprehensive care packages, counselling and community support services.
- Accurate and current information on STI/HIV/AIDS issues need to be disseminated to DHMTs, health centres, private clinics and community groups in a systematic manner.
- District multi-sectoral HIV/AIDS Taskforces and Youth Advisory Boards can create a forum for innovative approaches to addressing HIV/AIDS locally.
- Integrating HIV/AIDS prevention into STI and other health services highlights the need for procedures and skill in dealing with issues of confidentiality.
- Community prevention efforts need to include activities that address the basic inequities underlying women and young girls' vulnerability to HIV/AIDS such as power imbalances and gender roles.
- Incentives for peer educators can sustain motivation and enthusiasm. IEC materials, transport support and even soap can be suitable incentives instead of money.

5.3 Way forward

All districts expressed their concern at the possibility of the project ending in three months. It is clear that DHMTs have limited resources and would be unable to sustain some activities undertaken through this project, specifically, the training and prevention activities. A number of DHMT staff raised the possibility of a staged withdrawal of funding to allow time to find new sources of funding and other ways to continue these activities.

In the remaining months of this project the following activities are expected to be undertaken:

- Printing and distribution of IEC material on MTCT.
 - Refresher courses for health care workers in syndromic management, VCT and MTCT
- Where possible a training module on attitudes, confidentiality provisions and HIV related stigma should be designed.

In relation to future initiatives the following areas should be considered:

In the short term in 5 districts:

- Continue with refresher training for health care workers and community health workers, including training on attitudes, confidentiality and HIV-related stigma
- Continue with training in syndromic management, focusing on training of trainers
- Increase training programs in HIV/AIDS counselling skills and MTCT issues, focusing on training of trainers
- Consolidate and strengthen STI management in existing districts through ensuring regular supplies of drugs and reagents
- Strengthen capacity for provision of HIV/AIDS counselling and referral for VCT through training and development of procedures and linkages between services.
- Strengthen skills and knowledge of health care workers and mothers support groups to support MTCT programs
- Strengthen youth programs through training, IEC materials and condom supplies
- Investigate the feasibility of incentives for youth programs
- Increase exchange visits and internships for young people
- Develop innovative ways to use trainers in districts

Initial efforts to scale up the activities of this project could begin during the bridging phase. Specifically;

- Scaling up youth programs in phased way through linking these with UNFPA and other peer education activities;
- Highlighting where districts are already attempting to sustain activities and developing ways that these efforts can be communicated and shared; and,
- Identifying ways in which the training component of project could reach other districts.

In the longer term, funding should be sought for this project to continue and be scaled up, provided that there has been an effort to address the constraints of integration evident in the current project. Any future project should build on the successes of the current project and on the likely outcomes of the activities in the bridging phase.

Specifically a future project should ensure that supplies of drugs and reagents are an integral part of the project and that there is a commitment by GRZ or donor groups to support this component. Within the next 12 months there may be some evidence of improvement to this system through donor initiatives. A future project should also ensure that there is a specific focus on strengthening MTCT and VCT programs, either in collaboration with other groups or through direct funding of these programs.

5.4 Recommendations

The recommendations from this evaluation are grouped into two areas: structural and contextual issues that impact on the successful implementation of future activities and specific activities that need to be undertaken. Attention should be given to strengthening the structural elements prior to scaling up activities in specific areas.

1. Structural and contextual issues

Drug access and supplies

- That regular supplies of STI and RPR kits are made available at the district level and that these supplies are available to all MCH facilities free of charge.
- That the provision of STI drugs and RPR kits at DHMT and health centre level is given high priority, to ensure that health centres maintain supplies either through using own funds or seeking other suppliers.
- That procedures are developed to enable DHMTs and health centres to buy drugs from wholesalers at a reduced rate when supplies are low.
- That there is further investigation of systems for ordering and distribution of supplies to identify difficulties in supply chain and develop processes for improvement.
- That districts take a more pro-active role in ensuring that condoms are available at public and private health centre and where necessary source socially marketed condoms for distribution.

Data and research

- That DHMT and health centre staff ensure that AIDS related conditions are diagnosed and recorded, possibly through the use of tally sheets.
- That data on STIs is disaggregated in HMIS and that this information is disaggregated by age and gender.
- That information collected at the health centre level is integrated to incorporate the donor and HMIS requirements.
- That operational research is undertaken at a number of project sites to identify contextual information for the development of appropriate interventions. This research could include:
 - Understanding of cultural barriers to change in relation to alternatives to breastfeeding
 - Impact of lack of RPR kits on rates of congenital syphilis
 - Acceptability of VCT services and reluctance to seek HIV testing
 - Identify issues facing women with HIV in community settings and impact of HIV on families and communities
 - Identify understandings of risk and risk related sexual behaviour among young people

VCT

- That the number of VCT sites in districts are increased and that some of these sites are co-located with MCH/FP facilities where possible.
- That DHMTs increase the number of trained VCT counsellors in each district.
- That mechanisms for referral and feedback are strengthened between health centres and VCT centres through training, written guidelines and supervisory support.
- That health centres identify ways that they can become more involved and linked with home based services for ongoing community care of people with HIV/AIDS

MTCT

- That comprehensive care packages focusing on the mother and child's nutritional and psychosocial needs are developed to reduce mother to child transmission of HIV.
- That HIV positive women are involved as educators in health centre and community activities

- That mothers support groups are strengthened to promote breastfeeding alternatives within local communities.
- That programmes are developed targeting men at community level to support women in STI treatment and prevention of mother to child transmission.

2. Specific activities

Training programmes

- That all training programmers for health care and community health workers should include modules on attitudes, confidentiality and stigma associated with HIV/AIDS.
- That specific skills training is undertaken for peer educators to assist young people with options for negotiating sexual relations including making choices around sexual behaviour and practices.
- That training programmes in HIV/AIDS counselling are increased.
- That refresher training for health staff and community health workers, particularly to reinforce the “super-market approach”, is conducted regularly in project districts.

Supervision

- That districts devise ways to provide more on-the-job training during supervisory visits particularly in relation to MTCT.
- That supervisory visits emphasise HIV/AIDS issues, particularly confidentiality and the reporting and diagnosis of AIDS related conditions.
- That all DHMTs establish focal DHMT staff for each health centres.

Community mobilisation

- That a tool to assess community participation is developed that includes the following:
 - Representation on health centre committees
 - Inclusion of communities in planning, monitoring and evaluation of health centre activities
 - Partnerships between health centres and communities
 - Level of satisfaction with health centre services
 - Assessment of health centre responsiveness to community concerns.
- That community mobilisation programs are strengthened to focus on gender sensitisation and empowerment of women and girls.
- That programmes are developed to encourage parents to talk to children about sexual issues eg parent-elder discussions, and men and women to talk together about these matters.

Youth

- That Youth Advisory Boards are established in all districts
- That youth services are assisted to undertake youth exchange visits, promotional activities and to strengthen their capacity for involvement in NHCs and to develop action plans.
- That a feasibility study of incentives for peer educators is undertaken in collaboration with the UNFPA 2001/2002 peer education evaluation.

- That partnering arrangements are developed with other agencies for skills development and income generation activities and to ensure that all youth friendly services have continuous supply of IEC materials and condoms

IEC

- That IEC material is developed to suit local contexts and languages and that youth and communities are actively involved in the development of this material.
- That drama programmes are strengthened in all districts to enable community groups to continue this form of health promotion.

APPENDIX 1

LOGFRAME

ZAMBIA: HIV/AIDS PREVENTION IN WOMEN PROJECT EVALUATION 1998 -2001

OUTPUTS	PERFORMANCE INDICATORS	COMMENTS
Component 1: Training of health workers in STD/HIV/AIDS diagnosis, treatment and counselling		
35 Trainers of Trainers (TOT) trained in HIV/AIDS diagnosis, management and counselling, STD syndromic diagnosis, treatment and counselling and teaching skills.	Number of TOT, clinical officers, MCH nurses, community health workers and TBAs trained	35 trainers have been trained in each district
200 clinical officers and MCH nurses trained in HIV/AIDS diagnosis, management and counselling, STD diagnosis treatment and counselling.	Number of TOT, clinical officers, MCH nurses, community health workers and TBAs trained	454 clinical officers, MCH nurses trained in 5 districts 109 people have received training in 5 districts
50 community health workers and TBAs trained in provision of information on STD/HIV/AIDS.	Number of TOT, clinical officers, MCH nurses, community health workers and TBAs trained	469 community health workers trained in the provision of information on STD/HIV/AIDS in 5 districts 420 youth have been trained
Component 2: Implementation of STD/HIV protocols within MCH/FP facilities at hospital and health centres		
557,000 women effectively screened for STDs according to national guidelines.	Number/(%) of women screened for STDs	697,299 women have been screened in 5 districts. This is 6.3% of women in the 5 districts
56,000 women with STDs treated according to national guidelines.	Number/(%) of women treated for STDs	43,923 (6.3%) women with STDs in 5 districts
Approximately 50% of partners of women with STDs treated according to national guidelines.	Number/(%) of partners treated for STDs	22,524 (51%) of partners have been treated for STDs
Decreased prevalence of HIV/AIDS in target areas by approximately 11,000 women who attend MCH/FP facilities.		There was no baseline data at commencement of project. HIV/AIDS available through MCH/FP facilities
All women with clinical symptoms of HIV/AIDS provided with counselling.		There was no data recorded. Clinic staff reported difficulties in providing information on HIV/AIDS
All women requesting an HIV/AIDS test appropriately referred.	Number/(%) of women referred for HIV testing	1652 (0.24%) of women referred for an HIV test
5% increase in pregnant women attending AN, PN and FP clinics.	Number/(%) of pregnant women attending ANC, family planning and postnatal clinics	No base line data was available at commencement of project. No change.
HIV sero-survey among antenatal women	HIV sero-prevalence survey among antenatal	This survey was not completed

Evaluation of the Project: Prevention and control of HIV/AIDS and STDS in women through the integration of STD/HIV/AIDS services into maternal child health/family planning facilities in 5 urban districts.

OUTPUTS	PERFORMANCE INDICATORS	COMMENTS
conducted.	women conducted	funds. In 1998 CBOH sentinel surveillance s in 5 districts
Implementation of STD/HIV protocols within 80 MCH/FP services at hospital and health centres focussing on counselling, referral services, screening, diagnosis and treatment.	Number of MCH/FP facilities implementing STD/HIV/AIDS protocols	102 health facilities im protocols in 5 districts
Component 3: Social mobilisation and development of appropriate IEC materials on STD/HIV/AIDS		
5000 booklets, 5000 leaflets and 5000 posters on STD/HIV/AIDS distributed.	Number and types of IEC material produced and distributed.	Pamphlets on MTCT H will be printed and dis project. 400 canvas bags to pro antenatal clinics have l
Radio program on STD/HIV/AIDS in local languages broadcast.	Numbers of community based IEC events with estimates of audience size and description of audience composition (male/female, approximate age, etc)	A number of radio broadcast in 3 distric
100 drama performances on STD/HIV/AIDS conducted.	Numbers of community based IEC events with estimates of audience size and description of audience composition (male/female, approximate age, etc)	More than 100 drama undertaken.
Component 4: Monitoring and Evaluation		
Bi-annual review meetings conducted.	Number of review meetings	3 inter-district review held
Final project evaluation by external consultant conducted.	Final evaluation by external consultant	Conducted May 2001
UNICEF Zambia monitoring/reviews.	UNICEF Zambia monitoring visits	Quarterly field monito conducted since 1999
3 UNICEF Australia monitoring visits/progress reports/project completion report.	UNICEF Australia monitoring visits, progress reports / project completion report.	2 UNICEF monitoring 2 Progress Reports sub

APPENDIX 2

TERMS OF REFERENCE FOR EVALUATION

1. To examine the extent to which project activities have met planned objectives and outputs as agreed in the project proposal (May 1998).
2. To examine the nature and magnitude of constraints and successes.
3. To analyse the enabling factors and obstacles to progress.
4. To identify lessons learned in relation to the following:
 - The process and level of integration of STD/HIV/AIDS services into Maternal and Child Health (MCH) services, other health services and programs.
 - The use of health staff to screen and treat for STDs.
 - The use of health staff to counsel and refer for HIV testing
 - Drug availability and supply.
 - The empowerment of individuals, families and communities through information communication and education (IEC) materials, appropriateness of the materials, their dissemination, utilisation and relevance of content.
 - Nature and level of community participation/involvement,
 - The extent to which the mobilisation of men and women around STD/HIV/AIDS has assisted in creating dialogue on sexual issues.
 - The Prevention of MTCT of HIV and VCT services.
5. To give an outline of the Government's view on the relative success and sustainability of the project.
6. To make recommendations as to how the project can be strengthened and whether it should be expanded to other parts of the country.

APPENDIX 3

PROGRAM OF EVALUATION

ITINERARY FOR THE EVALUATION FIELD VISIT

DAY/DATE/TIME	ACTIVITY and CONTACT OFFICER
Monday, 7th May 2001 08.00 hours 08.30 hours 10.30 hours 11.30 hours 14.00 hours 15.00 hours	Meeting UNICEF Staff and local consultants. <ul style="list-style-type: none"> Meeting with UNICEF staff. Mr. J. Mohan - Ag. UNICEF Rep., Ms. Tomoto Nishimoto Ag. Prog. Coordinator, Dr. D. Mulenga- OIC Health section, Siping Wang Proj. off. M/E. and Health Section staff Evaluation Team: Ms. Sarah Lendon, Ms. Anne Malcolm, Dr. K. Sunkutu., Dr. E. Sinyinza - Local consultants <i>Appointments</i> <ul style="list-style-type: none"> Dr. Bola, Director - National HIV/AIDS Council and Mr. C. Mwale CBOH STD/HIV/ AIDS Liaison officer. Mr. Tony Daly, DFID Dr. Karen Shelley, USAID. Evaluation team meeting - Evaluation tools and review Plan for field visits
Tuesday, 8th May 2001 9.30 hours 11.00 hours 12.00 hours 14.00 hours 15.00 hours 16.30 hours	Appointments <ul style="list-style-type: none"> Dr. G. Silwamba, Director General, CBOH Ms. S. Naomi Toyoshi, JICA. Rick Hughes, Elizabeth Serlemitsos, ZIHP Mr. Kikkan Haugen, NORAD Ken Ofosu-Barko, UNAIDS Evaluation team meeting
Wednesday, 9th May 2001 08.00 hours. 09.00 hours 11.00 to 17.00 hours	Field visits commence Field visit to Lusaka DHMT. <ul style="list-style-type: none"> Meeting - Provincial Director of Health, and DDH, DHMT staff Review of project documentation at DHMT office Visit health centres and communities (Chelstone, Mtendere, Kalingalinga and Bauleni). PPAZ clinic at 14.00 hours.
Thursday, 10th May 2001 07.00 hours	Field visits to Livingstone Travel to Livingstone.
Friday, 11th May 2001 08.00 hours 09.00 hours 11.00 - 17.00 hours	Field visits to Livingstone <ul style="list-style-type: none"> Meetings - Provincial Director of Health, and DDH, DHMT staff. Review of project documentation at DHMT office. Visit health centres and communities. {Airport, Boma, Dambwa, Libuyu, Shafi and Royal clinic}

Saturday, 12th May 2001 10.00 hours	Travel to Lusaka.
Sunday 13th May 2001 11.00 hours	Travel to Ndola
Monday, 14th May 2001 08.00 hours 09.00 hours 11.00 to 17.00 hours	Field visit to Ndola DHMT <ul style="list-style-type: none"> • Meetings - Provincial Director of Health, and DDH, DHMT staff. • Review of project documentation at DHMT office • Visit health centres.
Tuesday, 15th May 2001 07.00 hours 08.00 hours 09.00 hours 11.00 to 17.00 hours 18.00 hours	Field visit to Kitwe DHMT Travel to Kitwe <ul style="list-style-type: none"> • Meeting DDH and DHMT staff. • Review of project documentation at DHMT office • Visit health centres • Depart for Ndola
Wednesday, 16th May 2001 07.00 hours 10.00 hours 17.00 hours	Travel to Lusaka <ul style="list-style-type: none"> • <u>Non project site</u> - Kabwe DHMT. • Meeting with - Provincial Director of Health, and DDH, DHMT staff • Visit health centres. • Depart for Lusaka
Thursday, 17th May 2001	Analysis of Evaluation Team's findings, finalisation of Evaluation Team recommendations.
Friday, 18th May 2001 09.00 - 10.00hours	<ul style="list-style-type: none"> • Debriefing to UNICEF staff and project counterparts on findings and recommendations - UNICEF Conference room.

APPENDIX 4

PEOPLE AND ORGANISATIONS CONSULTED

UNICEF LUSAKA

Ms. Stella A. J. Goings	UNICEF Rep.
Mr. James Mohan	Ag. UNICEF Rep.
Ms. Tomoto Nishimoto	Ag. Programme Coordinator
Dr. Doreen Mulenga	Officer In-Charge, Health section
Ms. Siping Wang	Project Officer, Monitoring/Evaluation
Dr. Marzio Babilie	Consultant, Health Section
Dr Haritiana Rakotomamonjy	MTCT Officer, Health Section

CENTRAL BOARD OF HEALTH

Dr. Gavin Silwamba	Director General
Mr. Clement Mwale	STD/HIV/ AIDS Liaison officer
Mrs. Debby Choongo	Gender / Community Partnership Specialist

NATIONAL HIV/AIDS COUNCIL

Dr. G.K. Bola, Director	Director
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USAID

Dr. Karen Shelley	Senior Technical Adviser for HIV Programs and Child Survival
Elizabeth Serlemitos	Chief of Party, ZIHP
Rick Hughes	Associate Director, ESA, Country Director, Zambia

DFID

Mr. Tony Daly	Health and Population Sector Coordinator
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JICA

Ms. S. Naomi Toyoshi	Project Formulation Adviser
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NORAD

Mr. Kikkan Haugen	First Secretary, Development Cooperation
Ms Dorothy Hamuwele	Programme Officer

WHO

Dr. Eddy Limbambala	Disease Prevention and Control Officer
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UNFPA

Mrs. Beatrice Chikotola	National Programme officer
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UNAIDS

Dr. Kenneth Ofosu- Barko	Country Programme Adviser
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LUSAKA DISTRICT

DISTRICT HEALTH MANAGEMENT BOARD

Dr. Sinkala	District Director of Health
Mrs. Alexandria Mwale	MCH Coordinator
Mrs. Mary Banda	UCI/Adolescent Health Coordinator
Mr. Simona	Clinical Officer - Lilayi Clinic

WESTVIEW MEDICAL CENTRE (private)

Dr Usha Padmanabhan	Chief Medical Officer
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KALINGALINGA CLINIC

MTENDERE CLINIC

Mrs Chikwanda	Nurse
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CHELSTON CLINIC

Mrs Ingutu	Nurse
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PPAZ CLINIC

BAULENI CLINIC

LIVINGSTONE DISTRICT

PROVINCIAL HEALTH OFFICE

Dr. Mukonka	Provincial Director of Health
Dr. Anne Vestjens	Technical Adviser, Southern and Western Provinces
Mr. Simbambala	Environmental Health Officer

DISTRICT HEALTH MANAGEMENT BOARD

Mrs. T. Mainga	Manager Planning and Development
Mr. M. Bwalya	Manager Administration
Mr. P. Bwalya	Information Officer
Mrs. D. Nkhatya	Senior Environmental Health Technician
Mr. W. Siasulwe	Nutritionist
Mr. R. Kakulubelwa	Clinical Officer in Charge
Mr. C. Sikazindu	UN Volunteer HIV/AIDS Officer (SEPO Centre)
Ms. M. Mweemba	IEC Coordinator/ UNV (SEPO Centre)

AIRPORT CLINIC

Mrs. Anne S. Chonza	Enrolled Nurse Midwife/In-Charge
Mrs. Mary Lutaka	Enrolled Midwife/Family Health Nurse/Counsellor
Ms. Jane Chonza	Classified Employee
Mr. Durton Nanja	NHC Acting Chairperson
Mr. Danny Kabinga	NHC Member

Mrs. Margaret Liwanga	Community Health Worker
Mr. Boniface Mwenda	Community Based Distributor/ NHC Member
Mrs. Getrude Siwanga	Trained Traditional Birth Attendant
Mrs. Catherine Mubiana	Trained Traditional Birth Attendant
Ms. Dorothy Sililo	Peer educator - YFHS
Ms. Clara Chitangila	Peer educator - YFHS
Ms. Mildred Nyambe	Peer educator - YFHS

DAMBWA CLINIC

Mr. Greenford Sibusenga	Clinical Officer-in-Charge / Trainer
Mrs. Godfridah Chiyanzo	Sister-in-Charge / Trainer
Mrs. Chipunza	Family Health Nurse
Mrs. Anna M.Kalenga	Nurse Midwife / YFHS Focal Person
Mr. J. Malasa	NHC Chairperson
Mrs. Susan Kambole	NHC Member
Mrs. M. Inambao	NHC Member
Mr. Ronald Kalifungwe	Peer Educator - YFHS

LIBUYU HEALTH CENTRE

Mrs. G.C. Bbole	Enrolled Nurse Midwife / Acting Sister-in-Charge
Mrs. Judith Chilombe	Enrolled Nurse
Mrs. C. Chikakupaku	Enrolled Nurse Midwife
Mrs. E.M. Nachongo	Enrolled Nurse
Mrs. B.M. Shandumba	Enrolled Nurse Midwife
Mr. Mainza	NHC Chairperson
Mr. Mugala	NHC Vice Chairperson
Mrs. Cynthia Imasiku	NHC Member

BOMA CLINIC

Mr. M. Ziwa	Peer Educator
Mr. Mambwe Besa	Peer Educator

SEPO CENTRE

Mr. C. Sikazindu	UN Volunteer / HIV/AIDS Officer (SEPO Centre)
Ms. A. Katiba	FHN Counsellor
Ms. M. Mweemba	UN Volunteer / IEC Coordinator

SHAFIK CLINIC (PRIVATE)

Dr. Shafik	Medical Doctor/Director
Mrs. Grace Shafik	
Mrs. Mary Namambo	Nurse
Mrs. Ruth Malombola	

ROYAL PROFESSIONAL MEDICAL SERVICES (PRIVATE)

Mr. Lewis Jere	Clinical Officer/Clinic Manager
Mr. Richard Mwanza	Lab. Technician

Mr. George Ziba	Clinical Officer
Mrs. Patricia Chunti	Nurse
Ms. Violet J. Imbula	Receptionist

NDOLA DISTRICT

PROVINCIAL HEALTH OFFICE

Dr. Peter Mijere	Provincial Director of Health
Florence	Clinical Adviser

DISTRICT HEALTH BOARD

Dr. M.K. Lembalemba	Acting District Director of Health
Mrs. F. Simwinji	MCH Coordinator

NEW MASALA CLINIC

Mr. Elastus Mwelwa	Peer Educator /Chairperson
Mr. Matthews Kapenda	Peer Educator / Vice Chairperson
Ms. Linda Whaleka	Peer Educator / Secretary
Mr. Brian Mutale	Peer Educator / Vice Secretary
Mr. John S. Mubita	Peer Educator / Vice Publicity
Mr. Anthony Phiri	Peer Educator / Disciplinary committee
Mr. Rodrick Katongo	Peer Educator / Member
Mr. Andrew Chisanga	Peer Educator / Member
Mr. Munali Mwala	Peer Educator / Member
Ms. Patricia Bwalya	Peer Educator / Member
Mr. Melak	Peer Educator /Member

TWAPIA CLINIC

Mrs. Mwafuililwa	Sister in Charge
Mrs. M. Malama	Nurse Midwife
Mr. Lastone S. Liselo	Peer Educator / Spokesperson
Mr. Abraham C. Kamanga	Peer Educator / Chairperson
Mr. Francis Katongo	Peer Educator
Mr. Roy Chama Chewe	Peer Educator / Drama Director

TELNOR CLINIC (Private)

Dr. Mulenga	Manager
	Nurse

BWAFWANO CLINIC

Mrs. Miti	Sister-in-Charge
Mrs. Nachinda	MCH/FP Nurse
Mrs. Munguya	MCH/FP Nurse

KITWE DISTRICT

DISTRICT HEALTH MANAGEMENT BOARD

Dr. W. Kanweka	Acting District Director of Health
Mrs. Mary Sieta	Acting Manager Planning

Mrs. Kungamina	YFHS Focal person
Mrs. Mubita	MCH Coordinator
Dr. Liyungu	Technical Adviser
Mrs. Hazemba	Nutritionist

CHIMWEMWE CLINIC

Mrs. Gondwe	Sister-in-Charge
Mr. Lottie Mwale	Peer Educator
Mr. Rogers Mwewa	Peer Educator
Mr. Richard Singemba	NHC Member

BUCHI CLINIC

Ms. Judith Chishimba	Nursing Sister
Ms. Rose Chileshe	Nurse
Ms. Roice Chanda	Nurse
Ms. Cecilia Kasomo	Nurse
Mr. Danny Mulenga	NHC Chairperson
Mr. Andrew Phiri	NHC Member
Ms. Febby Kangwa	NHC Member
Ms. Rachel Ihafwa	NHC Secretary

COPPERBELT UNIVERSITY CLINIC

Mr. Nawa Sanjobo	Clinical Officer
Ms. Micah Mwale	Sister in Charge
Ms. Shelley H.Mwemba	Registered Midwife
Ms. Belia Namumba	Enrolled Nurse Midwife

LUANGWA CLINIC

NDEKE CLINIC

KABWE DISTRICT

KABWE DISTRICT HEALTH MANAGEMENT BOARD

Dr. D. M. Suya	District Director of Health
Mr. H. M. Fumbeshi	Manager Administration
Mrs. V.M. Mwape	Acting Manager Planning & Development
Mr. J.M. Chifwembe	TB/STD/HIV/AIDS Coordinator

MAHATMA GANDHI HEALTH CENTRE

Mrs. D. Kasanda	Family Health Nurse
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POLLEN CLINIC

Mrs. Eveline Mfula	Nurse Midwife
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