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Community Health Service Gap Analysis at District, Health Facility and Community Level

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Abt Associates Inc. ■ 4550 Montgomery Avenue, Suite 800 North
■ Bethesda, Maryland 20814 ■ Tel: 301.347.5000 ■ Fax: 301.913.9061

Community Health Service Gap Analysis at District, Health Facility and Community Level

Co-authors
Anna Chirwa, Community Health Coordinator - Lusaka Province
Danford Makayi, Community Health Coordinator - North-Western
Eridge Simukanzye, Community Health Coordinator - Southern Province
Euphrasia Mtonga, Community Health Coordinator - Central Province
Mukata Mulonda, Community Health Coordinator - Eastern Province
Jones Malambo, Community Health Coordinator - Western Province
Judith Sakeyo, Community Health Coordinator - Northern Province
Timothy Silweya, Community Health Coordinator - Western Province
Wendy Nyekele, Community Health Coordinator - Copperbelt Province
Muriel Syacumpi, Community Liaison Specialist - Lusaka, National office

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Abbreviations/Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behavior Change Communication
CBO	Community-based Organisation
CHC	Community Health Coordinator
CHN	Child Health and Nutrition
CHW	Community Health Worker
C-IMCI	Community-Integrated Management of Childhood Illness
DATF	District AIDS Task Force
DHMT	District Health Management Team
DMO	District Medical Office
FP	Family Planning
HIV	Human Immunodeficiency Virus
IRS	Indoor Residual Spraying
ITN	Intermittent Treated Bed Nets
MOH	Ministry of Health
MNC	Maternal and Neonatal Care
NGO	Non-governmental Organisation
NHC	Neighborhood Health Committee
PA	Performance Assessment
PHO	Provincial Health Office
PMO	Provincial Medical Office
RH	Reproductive Health
RHC	Rural Health Center
RDT	Rapid Diagnostic Test
RED	Reaching Every District
TSS	Technical Supportive Supervision
ZISSP	Zambia Integrated System Strengthening Programme
SMAG	Safe Motherhood Action Group
VCT	Voluntary Counseling and Testing

1. Introduction

The Zambia Integrated Systems Strengthening Program (ZISSP) seeks to strengthen the health system by working with the Ministry of Health (MOH) and focusing particularly on high-impact health services for HIV/AIDS, malaria, family planning (FP), maternal and neonatal care (MNC), and child health and nutrition (CHN). Together ZISSP and the MOH will strengthen the health system's building blocks by working horizontally to improve planning, management, and service delivery at each level of the health system. ZISSP's technical team will provide technical support at the national, provincial, district and community levels of the system.

ZISSP is working in all 9 provinces of Zambia, concentrating its community efforts in 27 selected districts. At the community level, ZISSP Community Health Coordinators (CHC) will work in target districts to build the capacity of community groups to advocate for their health needs as active participants in the health planning process. The CHCs will also assist communities and local organizations to develop and implement locally-led behavior change communication (BCC) plans. Additionally, ZISSP will partner with the MOH to support implementation of the community health worker (CHW) program and strengthen services delivered by the CHWs. CHCs will also assist District Medical Officer's teams to engage community-based organisations (CBO) to become more integrated in local health service delivery.

1.1 Purpose of the Report

This report presents findings from a gap analysis that was conducted by the CHCs at the inception of their engagement in each province. The CHCs focused on gathering information on planning, implementation, and evaluation of health programming happening at the community and district levels. The report also identifies gaps that exist within current activities and suggests possible interventions that may be adopted to address them.

2. Methodology

Each CHC used several methods to gather information about health care delivery and programming at district and community levels within their assigned provinces. Group discussions were held with members of the Neighborhood Health Committees (NHCs), CHWs, and health center staff. Short interviews were held with key staff at the Provincial Medical Offices (PMOs) and District Medical Offices (DMOs), health facility providers and local non-governmental organizations (NGOs) in the community. A list of persons interviewed can be found in Annex 1. A desk review of facility reports and records was conducted. A review of MOH Performance Appraisals in all districts was also conducted.

3. Summary of key findings

The outcome of this analysis is presented below in the following three categories pertaining to health programming: activity planning, programme implementation, and programme evaluation.

3.1 Activity Planning

The first step of health care delivery at district and community levels is the planning phase. During this phase, the districts support the formation of community and health facility plans for health programming. The District Medical Officer, who heads the district health management teams (DHMTs), is responsible for overseeing these planning activities. Planning units at the district level coordinate planning-related activities and ensure that the communities have submitted their plans for compilation into one Health

Centre plan. The Health Centers then submit their one year plan to the district for consolidation into one district plan.

The District Planner, in conjunction with program staff members, conduct planning meetings with the health facilities, where participants share information and updates on key health areas (such as malaria, CHN, MCN, reproductive health (RH)/FP, and HIV/AIDS) and indicative planning figures for budgeting. As a result of these meetings, the staff gains new or updated information to share with community leaders and include in their facility plans. Facilities also hold meetings with NHCs to share updates, gather community input on health programming needs, and determine priority areas for inclusion in the community plans and. With guidance from the health facilities, NHCs prepare activity plans and submit them for inclusion into the health facility plans. Health facility plans are then included into the district plan.

3.1.1 Activity Planning Gaps

The analysis revealed several gaps within the activity planning process. First, there is weak participation of communities in planning activities and the existing participation is not adequately coordinated and facilitated by health center staff. Second, faith-based organizations, key community groups, like the NHC and CHWs, and opinion leaders in the community are not adequately involved in the planning process, particularly at the community level. Also, NHC staff is not well versed in the planning process and do not have an adequate understanding of their role and responsibilities during the planning cycle. The process also lacks guidelines and other simple planning tools that specifically outline the steps for members of the NHC to follow during planning activities. Finally, no BCC plans exist at the district and community levels, most likely because some districts do not have key individuals responsible for BCC activities.

3.2 Programme Implementation

Implementation of the community activities begins immediately after the health facility receives an approved plan and budget from their respective DHMT. The health center in-charge convenes a meeting with the health center and the NHCs to discuss the implementation process. The community activities are then monitored by the health center staff.

3.2.1 Programme Implementation Gaps

Programme implementation at the district, health facility and community levels has various challenges. Service delivery is affected by a shortage of staff at the health facilities, decreasing in the quality of services and slowing down initiatives to integrate health care services. Also, community health groups participating in the provision of health care services receive supervision from health center staff, however it is often inadequate and of poor quality.

Community activities are not adequately meeting the health needs of the communities. Health facilities are supposed to support the implementation of community health outreach activities, however, in most facilities, the resources to do so, both financial and human, are inadequate. Despite the interest in participating, shortage in staff frequently prohibits health center staff to take part in such outreach activities. This can also hinder actual program implementation. The outreach activities that *are* undertaken by the health center staff, often times do not adequately involve community health groups, causing many groups to feel left out and unappreciated.

The analysis also found that health promotion materials intended to reach communities are not effectively distributed. This results in sporadic and insufficient information flow to communities. Furthermore, as mentioned above, some districts do not have key individuals responsible for BCC activities and therefore existing BCC activities are not receiving the support and attention needed for successful implementation.

Different stakeholders maintain different policies regarding incentives for CHWs. For example, some NGOs working in Luangwa District in Lusaka Province pay their volunteers lunch allowances during special events, while other NGOs in Namwala in Southern Province give CHWs material incentives, such as bicycles, T-shirts, Chitenge cloth, caps etc. There are also many CHWs who are not 'adopted' by NGOs and therefore are not receiving such benefits. This has led to the de-motivation of many volunteer CHWs.

3.3. Programme Evaluation

The evaluation of community activities is one of the major roles of the health center. The process and frequency of evaluation is usually discussed during the planning process and communities are always aware when such activities would be happening. The evaluation mostly examines how the planned activities have been implemented, taking into consideration the timing of the implementation and the output or results of such interventions. The evaluation also looks at the results, whether positive or negative, and provides opportunity for communities to replan and address identified gaps.

3.3.1 Programme Evaluation Gaps

Evaluation of health services and outreach activities is not a standard practice for community health services at district, health facility or community levels. The current mechanism used to evaluate health facilities is the Performance Assessment (PA) tool, however it is the only official evaluation method currently being used and does not address performance at the community level. The PA is usually followed by technical supportive supervision (TSS), however due to a lack of resources, this does not always occur. Also, the PA tools are not sufficient for the evaluation of community level activities, hence the PMO team has recognized the need to revise the tool to include aspects of the community.

The analysis also noted that supportive supervision is the only mechanism for districts and health facilities to provide technical updates for service delivery at the community and lower health facility levels.

4. Other Findings

During the analysis, gaps were identified in other key ZISSP focus areas, including malaria, HIV/AIDS, CHN, FP/RH, and MNC. A summary of these gaps and proposed strategies to address them can be found in Annex 2.

5. Strategies to Address the Identified Gaps

This section provides strategies to address the identified gaps in the three health programming areas: activity planning, programme implementation, and programme evaluation.

5.1 Activity Planning

The main gaps identified in activity planning exist at the community level. This includes weak community participation of local organizations and community groups, lack of guidance and tools for the planning process, and lack of BCC plans. To address these identified gaps the following strategies are suggested:

- Develop protocol(s) that will provide guidance for community level participants on the planning process, such as, how, when, and why planning is carried out, what must be included in the process, and roles and responsibilities. Such a tool will inform health center staff of their role in the process and clarify expectations for facilitating and supporting the planning process at the community level.
- Conduct orientation of health center staff and NHCs, CHWs, opinion leaders and other community health groups to the Participatory Learning for Action planning process[1].
- Sensitize communities to their roles and responsibilities in the planning process and health promotion and BCC activities.
- Develop a tool that provides details of the roles and responsibilities of NHCs, volunteer CHWs and other community health groups in health promotion and BCC activities at the community level.
- Conduct a training needs assessment of NHCs, volunteer CHWs, and opinion leaders, related to their roles and responsibilities in health promotion and BCC.
- Conduct an orientation with key community groups on BCC planning and messaging.

5.2 Programme Implementation

The main gaps in programme implementation include a shortage of human resources to deliver quality services and provide community outreach, weak involvement of community groups in outreach activities, poor distribution of health promotion and BCC materials, and a varying incentive scheme for CHWs. To address these identified gaps in programme implementation, the following strategies are suggested:

- Promote health center quarterly meeting to review the implementation of activities.
- Support stakeholder meetings for the purpose of leveraging resources for service delivery.
- Strengthen the system of supervision by developing user-friendly training tools and training health center staff to provide effective supervision of community health groups.
- Promote health center quarterly action planning reviews to monitor the performance of the district and community level activities.
- Support the formation of community groups, like volunteer CHWs, that will be oriented in health care delivery and health promotion in the community.
- Conduct an assessment of existing health promotion and BCC materials in PMOs, DHMTs, and health centers and identify gaps. Seek BCC materials from NGOs and other organizations to fill such gaps.
- Support strengthened distribution of BCC materials through CHWs and other community groups.
- Provide grants for CBOs to champion BCC activities at the community level.
- Engage partners during partnership meetings to support the expansion of service delivery coverage by CHWs using available resources.
- Coordinate stakeholders and agree on standardization of incentives for CHWs.

5.3 Programme Evaluation

1 The Participatory Learning for Action planning process allows for communities to be active players in the planning cycle for health intervention activities that involve them. The communities participate in identification, prioritization of health issues affecting them and agreeing on processes of implementation, monitoring and evaluation of interventions.

The main gaps in programme evaluation include a lack of sufficient evaluation tools, specifically for community level activities, a lack of resources hinders proper implementation of the PA process, and insufficient opportunities exist for technical feedback from district and health facility levels to the community level. To address these identified gaps, the following strategies are suggested:

- Review and revise the PA tool to include assessments at the community level.
- Support and strengthen TSS activities for health center staff to the community.
- Support quarterly district stakeholder meetings for sharing of information and best practices.
- Strengthen community networks of health providers and community groups to increase sharing of key health-related information.

6. Conclusion

Although the gap analyses did not include all 27 ZISSP districts, the information contained in this report provides the CHCs with an improved understanding of the environment in which they will be working with regards to health service planning, implementation and evaluation. This analysis is also a solid basis for identifying priority areas for community level planning and implementation.

Annex 1: List of Persons Interviewed During the Gap Analysis

No.	Name	Designation	Station
1.	Mr. Mutale	Clinical Care Officer	DHMT, Sesheke
2.	Mr. Mwilaba	Medical Licentiate	Kaoma District Hospital
3.	Mr. Nkhata	Clinical Care Officer	DHMT, Kaoma
4.	Mr. Shabalala	Malaria Focal Point person	DHMT, Kaoma
5.	Mrs. Cheembo	Public Health Officer	DHMT, Kaoma
6.	Dr. Yumba	District Medical Officer	DHMT, Kaoma
7.	Dr. Liwali	District Medical Officer	DHMT, Mongu
8.	Mr. Mubita Mubita	Provincial Planner	DHMT, Mongu
9.	Dr. Sitali	Provincial Health Director	PHO, Mongu
10.	Mr. Phiri	Chief Environmental Health Officer	PHO, Mongu
11.	Mr. S. Litebele	Senior Health Inspector	PHO, Mongu
12.	Mrs. B. Lubinda	Surveillance Officer	PHO, Mongu
13.	Mr. Sibeso	Data Manager	PHO, Mongu
14.	Mrs. Masuwe	Registered Nurse	Masese, RHC, Mongu
15.	Mr. Muleta Mulete	NHC Member	Masese, RHC, Mongu
16.	Mr. Muhau	NHC Member	Masese, RHC, Mongu
17.	Mrs. Nyambe	Enrolled Nurse	Zambezi Sawmills RHC, Sesheke
18.	Mrs. Mubiana	Classified Daily Employee	Zambezi Sawmills RHC, Sesheke
19.	Mr. Johanzi Mvula	Monitoring and Evaluation Officer	CDC, Zambezi
20.	Mr. Boniface Kabungo	Laboratory Technician	Biomedical Science, Livingstone General Hospital
21.	Mrs. Lucensia Himwila	Principal Nursing Officer	PHO, Livingstone
22.	Mr. Emmanuel Khoma	Chief Environmental Health Officer	PHO, Livingstone
23.	Dr. Davy Kaile	District Medical Officer	DHMT, Namwala
24.	Dr. Kasoma	District Medical Officer	DHMT, Itezhi-Tezhi
25.	Mr. Innocent Hamuganyu	Public Health Officer	DHMT, Namwala
26.	Mr. A. Mhango	Acting Executive Director	Macha Mission Hospital
27.	Mr. Malambo Maurice	Enrolled Nurse, In-charge	Mbila RHC
28.	Mathews Lukunga	Environmental Health Technologist In-charge	Mbila RHC
29.	Mr. Masati	Environmental Health Technologist In-charge	Nanzhila RHCs
30.	Mrs. Fulgensia	Senior Community Development	Kasama

	Mwansa.	Office	
31.	Mr. Arnold Mulenga	Senior Health Education Officer	PMO, Kasama
32.	Mrs. Doris Mwape	Principle Nursing Officer Maternal and Child Health	PMO, Kasama
33.	Ms. Josephine Mwango	Program Management Coordinator	ZPCT II, Mansa
34.	Mrs. Mugala	Principle Nursing Officer Standards	PMO, Kasama
35.	Dr. Silwimba	Acting Provincial Medical Officer	PMO, Kasama
36.	Mr. P. Kasongo	Senior Human Resources Officer	PMO, Mansa
37.	Mrs. Sabina Miti	Capacity Building Initiative Coordinator	Care International, Mansa
38.	Mr. Kennedy Choba	Senior Health Information Officer	PMO, Mansa
39.	Dr. Wajilovia Chilambo	Clinical Care Specialist	PHO Lusaka
40.	Ms. Grace Nakawala	Senior Nursing officer -MCH	PHO Lusaka
41.	Mrs. Precious Kalubula	Surveillance Officer	PHO Lusaka
42.	Ms Florence Ngala	Chief Environmental Officer	PHO Lusaka
43.	Mrs. Kanene	PHN/Community Health Nurse	DHMT, Lusaka
44.	Mrs. Mshanga	Community Health Nurse	DHMT, Lusaka
45.	Mrs. Imasiku	Public Health Nurse	DHMT, Lusaka
46.	Dr. Msiska	District Director of Health	DHMT, Chongwe
47.	Dr. Bwalya	District Director of Health	DHMT, Luangwa
48.	Mr. Dindi Myoba	Health Provider	DHMT, Luangwa
49.	Mr. Choolwe Chikasha	Program Officer	Childfund, Luangwa
50.	Mr. Kawama M.C.	District AIDS Task Force Coordinator	DATF, Luangwa
51.	Dr. Liabwa	Provincial Medical Officer	PMO, Solwezi
52.	Mrs. Chisinda	Health Provider	Solwezi General Hospital
53.	Dr. Kunda	District Medical Officer	Solwezi General Hospital
54.	Dr. N`guni	District Medical Officer	DHMT, Solwezi
55.	Dr. Mutimushi	District Medical Officer	Mukinge Mission Hospital Kasempa
56.	Dr. Chisenga	District Medical Officer	DHMT, Zambezi
57.	Mr. Manda	Health Provider	DHMT, Zambezi
58.	Mr. Mwansa	Health Provider	DHMT, Zambezi
59.	Mrs. Ganeti Mulenga	Programme Officer	UNFPA, Solwezi
60.	Mr. F. Livayi	Health Provider	Mpidi RHC Zambezi
61.	Mr. Mukwakwa	Health Provider	Teachers College RHC Solwezi
62.	Mr. Kayumba	Human Resource	PHO, Solwezi
63.	Mr. Marshal Sikandangwa	Acting Clinical Care Specialist	PHO, Solwezi
64.	Mr. Kambowe	Provincial Nutritionist	PHO, Solwezi
65.	Mr. Soko	Nutritionist	Chipata District Health Office

66.	Mr. Kafula	TB/HIV focal Point Person	Nyimba
67.	Mr. Kanta Matipa	Data Associate	CIDRZ, Nyimba,
68.	Mrs. Nkhuwa Jennipher	Health Provider MCH	Nyimba District Hospital
69.	Mr. Chama	Provincial AIDS Coordinating Advisor	Eastern Province
70.	Sister Zephaniah Mutale	MCH Coordinator	Nyimba District Hospital
71.	Mr. Lamerk Daka	ENT Specialist	Nyimba District Hospital
72.	Mr. Henry Mbewe	Enrolled Nurse	Kalingindi Health Post, Nyimba
73.	Mr. George Chigali	Regional Manager	ZPCT II
74.	Mr. Kennedy Khama	Health Provider	DHMT, Kabwe
75.	Mr. Lloyd Cheelo	Provincial AIDS Coordinating Advisor	Central Province, Kabwe
76.	Mr. Elizabeth Chuma	Head of Department of Agriculture	Kabwe
77.	Mr. Mbulo	Environmental Health Officer	PMO, Mansa
78.	Mr. Mvula	Information Officer	PMO, Mansa
79.	Mr. Kabwe	Environmental Health Technologist	Chisunka RHC Mansa District
80.	Mr. Sindila Mumbula	Environmental Health Technologist	Kalyongo RHC Mansa District
81.	Mr. Ngulube	District Environmental Health Technologist	Mwense District
82.	Dr. Chandwe Ng'ambi	Provincial Medical Officer	PHO, Ndola
83.	Dr. Clara Nauluta	Communicable Disease Specialist	PHO, Ndola
84.	Mr. Mwape Jonnathan	Senior Health Education Officer	PHO, Ndola
85.	Ms. Florence Kashita	Human Resource and Development Officer	PHO, Ndola
86.	Mr. Patrick Mubiana	Senior Environmental Specialist	PHO, Ndola

Annex 2. Gaps Identified in Other Key ZISSP Focus Areas and Proposed Strategies to Address Them

ZISSP Focus Area	Identified Gap	Proposed Strategies to Address Gaps
Malaria	Indoor residual spraying (IRS), intermittent treated bed nets (ITNs), rapid diagnostic test (RDT) services are insufficient and erratic in some areas and there are few community-based volunteers working as malaria agents.	• Support and strengthen IRS activities at district and community levels. • Encourage and assist communities to identify health problems related to malaria and seek ITN and RDT services at the health facility level. • Link malaria related activities to the health facility plans. • Strengthen the provision of ITN distribution at the community level through CHWs. • Ensure supplies for ITNs and improve IRS services in the community. • Support BCC activities to create awareness of malaria program. • Build capacity of community groups to carry out community education programme.
HIV/AIDS	There is low coverage of voluntary counseling and testing (VCT) activities in most rural areas.	• Advocate for VCT services (static and mobile) in hard-to-reach communities. • Support BCC activities in the community. • Form adherence support groups in the communities. • Support and conduct HIV/AIDS community sensitizations activities and ensure involvement of existing community groups. • Introduce the concept of champions in HIV/AIDS - individuals in the community living positive and who agree to work with the health facility
	Condom use is low.	• Support and strengthen community mobilization and sensitisation efforts around condom use. • Support the distribution of condoms at the community level by helping communities come up with innovative ways of condom distribution.
Child Health and Nutrition	There is an inadequate number of staff trained in community-integrated management of childhood illness (C-IMCI).	• Support training for CHWs and health centre staff in C-IMCI
	No clear strategies exist for addressing malnutrition in the communities.	• Seek partnerships with other key community level stakeholders to address food security at the household level.

ZISSP Focus Area	Identified Gap	Proposed Strategies to Address Gaps
Child Health and Nutrition (cont.)	Record keeping is poor at the community and facility levels, especially for community level intervention activities.	• Strengthen the support mechanism related to the availability of service delivery community registers at the community and facility levels. • Promote the Reaching Every District (RED) strategy and training of CHWs, Safe Motherhood Action Groups (SMAGs), and other community groups. • Work with RED committees for community mobilization to support community support for CHN services.
Family Planning and Reproductive Health	There is a lack of community FP services and low rate of people attending FP services and follow-up.	• Strengthen community FP services. • Train CHWs, SMAGs, and NHCs to provide FP services, including counseling. • Facilitate the introduction and integration of adolescent reproductive health education in schools and communities.
Maternal, Neonatal Care	The number of institutional deliveries is low.	• Conduct training needs assessments of SMAGs and develop training/retraining programmes to deliver and refresh knowledge and skills. • Conduct community mobilization efforts to support the establishment of SMAGs in communities. • Train traditional birth attendants to refer pregnant women to health facilities. • Orient community groups to understand and support identification and referrals of high risk pregnancies.
	Post-natal attendance is low and focused antenatal care is not being provided adequately.	• Facilitate the establishment of active SMAGs in all communities.