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**A Paper on How International Donor Agencies and Non- Governmental
Agencies have Undertaken, Commissioned or Used Health Research in
Zambia within the Past Five Years.**

**By Dr. Golden K. Bolla
Supported by International Development Research Centre
CANADA**

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LIST OF ACRONYMS

| | |
|-----------|---|
| ACT | Artemisinin Combination Therapy |
| AIDS | Acquired Immunodeficiency Syndrome |
| AL | Artemether + Lumefantrine |
| ALRI | Acute Lower Respiratory Infection |
| ANC | Ante-Natal Care |
| ART | Anti Retroviral Therapy |
| ARVs | Antiretroviral drugs |
| BHCP | Basic Health Care Package |
| CBOH | Central Board of Health |
| CBOs | Community Based Organizations |
| CHAZ | Church Health Association of Zambia |
| CHESSORE | Centre for Health Science and Social Research |
| CHWs | Community Health Workers |
| CIDA | Canadian International Development Agency |
| CQ | Chloroquine |
| CSO | Central Statistical Office |
| DANIDA | Danish International Development Agency |
| DFID | Department for International Development |
| DHMT | District Health Management Team |
| Economics | DoE Department of |
| FBO | Faith Based Organization |
| GEH | Governance Equity and Health |
| GFATM | Global Fund for AIDS, Tuberculosis and Malaria |
| GRZ | Government of the Republic of Zambia |
| HBC | Home Based Care |
| HCC | Health Centre Committee |
| HIV | Human immunodeficiency virus |
| JHPIEGO | John Hopkins Programme for International Education of Gynaecologists/Obstetricians |
| JICA | Japan International Cooperation Agency |
| MOFNP | Ministry of Finance and Planning |
| MOH | Ministry of Health |
| NGO | Non-Governmental Organization |
| NHA | National Health Accounts |
| NMCC | National Malaria Control Centre |
| PEPFAR | Presidential Emergency Plan for AIDS Relief |
| PHC | Primary Health Care |
| PHO | Provincial Health Office |
| PLWAs | People Living With HIV and AIDS |
| PMTCT | Prevention of Mother To Child Transmission |
| QN | Quinine |
| RAPIDS | Reaching HIV/AIDS Affected People with Integrated |

| | |
|---------|---|
| SCR | Development & Support |
| SFH | Socio-Cultural Research |
| SHARE | Society for Family Health |
| SIDA | Support for HIV and AIDS Response in Zambia |
| SP | Swedish International Development Agency |
| STIs | Sulphadoxine/Pyremethamine |
| SWAp | Sexual Transmitted Infections |
| TB | Sector Wide Approach |
| TBAs | Tuberculosis |
| TDR | Traditional Birth Attendants |
| TOR | Tropical Disease Research Centre |
| UN | Term of Reference |
| UNAIDS | United Nations |
| UNDP | United Nations AIDS Programme |
| UNFPA | United Nations Development Programme |
| UNICEF | United Nations Population Fund |
| ZAMFOHR | United Nations Children's Funds |
| ZANARA | Zambia Forum for Health Research |
| ZCCM | Zambia National Response to HIV and AIDS |
| ZDHS | Zambia Consolidated Copper Mines |
| ZHFC | Zambia Demographic Health Surveys |
| | Zambia Health Facility Census |

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EXECUTIVE SUMMARY

Introduction:

The International Development Research Centre (IDRC) commissioned this study from February 20 to March 20, 2006. The aim of the study was to document how international donor agencies and non- governmental organizations (NGOs) have undertaken, commissioned or used health research in Zambia within the past five years. Specifically, the study delved into who commissioned or conducted the research, when the research was undertaken, what were the findings and funding levels including the impact of the research at policy and implementation levels.

Scope of the Consultancy

This study was undertaken under the ambit of *Zambia Forum for Health Research (ZAMFOHR)* with support of the International Development Research Centre (IDRC) through Research Matters which is an initiative designed to support the effective exchange and transfer of sound research with policy and practice. It connects researchers with the users of research, capturing and synthesizing the lessons, experience, and evidence from Governance, Equity and Health (GEH) and related projects

Objective:

To document ‘how international multilateral/bilateral donor agencies and non-governmental organizations (NGOs) have undertaken, and commissioned or used health research in Zambia within the past five years’.

Methodology

Data were collected through one on one interview with international donors, NGOs, researchers from research institutions or organizations and through self administered questionnaire. Twenty five organizations were served with questionnaires. Out of these only eight responded to the questionnaire. A total of 54 operational research projects conducted between 2001 and 2006 were submitted either as reports or by completing the questionnaire. The papers were then analysed as to who sponsored them, at what cost, stage of execution, and the impact made to the health sector. One questionnaire was not included in the analysis because the researches were conducted outside the stated period. This report outlines how international donor agencies and NGOs have undertaken, commissioned and used operational health research in Zambia within the past five years.

Main Findings of the Study

The main findings were that all health research has been funded by the international donor agencies while the NGOs including public research institutions have been conducting health research. None of the multilateral responded to questionnaire. Among the bilateral donor agencies only one responded to the questionnaire including one International NGO. Thirty-nine percent of the research was focused on public health, 7% on clinical care, 11% on M&E and 39% on systems development.

Despite the fact that a lot of research is being undertaken, there still remain a gap between linking research to policy and implementation. Only 17% of researches have been able to influence policy development while 39% have influenced program implementation.

Conclusions:

From the researches collected that were commissioned or undertaken by International donor agencies and NGOs, is to some extent being used in program implementation, however, there are gaps between research and policy development. *What is needed is moving the agenda forward to accelerate the use of evidence from operational research to policy development and program implementation in Zambia.*

Recommendations:

1. **Development of Health Research Capacity in Zambia:** To build this capacity for Zambia, a study to determine capacities required to act on health research evidence in informing policy and program implementation need to be conducted. This will include determination of the available capacities on Health Research in Zambia and factors influencing utilization of health research outcomes within the context of the role of health research in national economic development.
2. **Establish an Institutional Framework for Health Research:** To do this, a systematic study of the current institutional setup for health research in Zambia to identify gaps needs to be done.
3. Most research is funded by the donors, the **Government of Zambia to include a Budget line in its budgeting process for health research and staff time** to conduct and promote utilization of health research outcomes in Zambia.
4. Reduce the gap between evidence and implementation prioritizing health research and integrate into routine health care practice, increasing the accessibility to evidence on health research through wide dissemination to all stakeholders and building greater links between the policy makers, researchers and the implementing agencies

BACKGROUND OF THE STUDY

INTRODUCTION

In limited resource constrained countries, financial resources continue to hinder expansion and provision of quality health services due to limited health budgets. This is further worsened by the social economic inequalities that limit access to health services of the poor and vulnerable groups. In the midst of all these changes, the demographic and disease patterns are posing new challenges to policy makers, health care providers, financiers and society. The way in which evidence is used in policy process is largely determined by the beliefs and values of policymakers. Policy analysis provides an opportunity for building consensus on critical health care issues. Understanding how health research evidence informs policy and implementation is critical to effective sustained improvements in the quality of service provided and improvements in the health status of the population.

Providing evidence to policy makers on policy questions they have may increase the relevance and impact of research. The move towards evidenced based approach to health services has gained momentum over the past two decades. It involves making research evidence more usable and strengthening the capacity of policy, management and decision makers to use it. Operational Research has a potential to benefit health care delivery systems and society in general. To realize this potential, capacity to conduct, demand and use results need to be developed. Operational research “is a process, a way of identifying and solving program problems (Fisher et al., 1991)”.

The Zambian health care system is pyramidal in structure. The district level provides Primary health care and first level care through health posts and health centres. The provincial level offers secondary level services, while the specialist services are found at tertiary level of the pyramid. In 1992, Zambia embarked on an ambitious exercise of health reform. The reform did not interfere much with the pyramidal structure, but aimed at empowering and thus improving the functionality of each level especially in national policy formulation, service provision and control over planning and budgeting, financial management and decision making at operational levels. The Central Board of Health (CBOH), invested heavily in institutional capacity building at all levels. The reformed district health system was identified as the mainstay of providing quality health care as close to the family as possible using primary health care as vehicle. Inherent in the reforms was community empowerment which was guaranteed through the National Health Policies and Strategies of 1992 advocating right of access to affordable and acceptable quality health care to all Zambians. Through the same spirit, the health workers and communities were trained and involved in planning for health within each district.

Donor Agencies and NGOs in Zambian Health System

The International donors (Multilateral and Bilateral) have been supporting the health sector in Zambia through the health SWAP. The government together with the donors embarked on health reforms. Together they attempted to map out the disease burden in Zambia and developed the Basic Health Care Package (BHCP) for delivery of health services. There are however very few NGOs that have been working on health issues per se. The Donors and NGOs have again unswervingly stood by government in the fight against HIV and AIDS.

Health Research in Zambia

Operational health research is and has always been an integral part of Zambia's health system. Cooperating partners have been at hand to help government to undertake surveys, monitoring and evaluation activities in various health fields. These among others have aimed at providing empirical evidence before committing financial assistance or to give justification for funding certain projects.

Through the health SWAP (pooling of resources through the district Basket and the extended Basket) the cooperating partners in the health sector have been working together to support programme implementation and it has been difficult for an individual partner to claim credit over certain achievements. Health research aimed at programmes or health systems development, has not enjoyed similar coordination among donors and government. Notwithstanding, there still are numerous research undertakings that are not shared or widely disseminated and worst still not used to influence Ministry of Health (MOH) policy formulation, strategic planning and institutional management. In addition, although there have been attempts to coordinate health research in Zambia, there has not been a sustainable coordinating mechanism to provide advise, guidance on health research in Zambia. Through the Central Board of Health the government developed the National Health Research Agenda which outlined health research priorities in Zambia, In addition, the capacity for health systems research within the public health institution was developed. It is not clear to what extent the research agenda has been used buy both the donors and NGOs.

SCOPE OF THE CONSULTANCY

This study was undertaken under the ambit of *Zambia Forum for Health Research (ZAMFOHR)* with support of the International Development Research Centre (IDRC) through Research Matters which is an initiative designed to support the effective exchange and transfer of sound research with policy and practice. It connects researchers with the users of research, capturing and synthesizing the lessons, experience, and evidence from Governance, Equity and Health (GEH) and related projects. GEH mission is to strengthen health systems, promote civil participation, and make research matter. It provides a bridge between researchers and research-users by supporting dissemination, consolidation, amplification, and utilization of ongoing results and processes.

Terms of Reference

This study was undertaken under the following Term of Reference (TOR):

Overall objective: –

To document ‘how international multilateral/bilateral donor agencies and non-governmental organizations (NGOs) have undertaken, and commissioned or used health research in Zambia within the past five years’.

Specific objectives:-

- *To document all health research conducted, commissioned and/or used by donor agencies during the past five (5) years in Zambia; to record all relevant details such as when a particular research was undertaken, commissioned or used? Who did it, how was it conducted, what were the funding levels and what was the impact of the research at the policy or implementation levels?*
- *To document all health research conducted, commissioned and/or used by non-governmental organization (NGOs); to record all relevant details such as when a particular research was undertaken, commissioned or used? Who did it, how was it conducted, what were the funding levels and what was the impact of the research at the policy or implementation levels?*

Expected Outputs

The report of this consultancy outlines how international donor agencies and NGOs have undertaken, commissioned and used operational health research in Zambia within the past five years. The report indicates:

- a) The focus of the type of research which has been undertaken by international agencies and NGOs.
- b) Whether the research results are being used for policy and program implementation. i.e. integration into national health policies and strategies
- c) The challenges that have been experienced

Methodologies and Tools

In order to address the terms of reference adequately, the following methodologies were used:

- a) **One on one interviews with international donors and NGOs-** this method is premised on the fact that it encourages frank exchange of views as there is no guided flow of thoughts. Persons being interviewed do bring up issues in a more spontaneous manner and avoids one feel that one is merely being used in completing questionnaires.

- b) **One on one interview with researchers from research institutions or organizations** -in most areas the international donors and NGOs, might have undertaken research studies through either individual consultants, consultant firms or other local agencies. Research consultants, consultant firms and/or NGOs directly involved in the study exercise were interviewed.
- c) **Questionnaire**- This tool was used in gathering information from all the informants- specifically designed for different groups. The questionnaire was served either at the time of making appointment or at the time of interviews. The questionnaires supplement information obtained through interviews.

LIMITATION OF THE STUDY

The study covered (a) international donors (multilateral and bilateral) and non-governmental organizations and (b) Researchers and public institutions that were commissioned to carry out health research studies based in Lusaka only.

STUDY FINDINGS AND ANALYSIS

RESULTS

Multilateral Donor Agencies:

Multilateral donor agencies are a pivotal pillar in the Zambian health system in that their support permeates all areas and levels of the health system. These agencies do commission research activities which are undertaken by various institutions or individual Researchers. Multilateral donor agencies have quite often co-funded national studies initiated by the Ministry of Health (MOH), such as surveys every two to five years, monitoring and evaluation activities that translate into quarterly, biannually or annually reports including Joint Annual Reviews. Data was collected chiefly through one on one interviews followed by serving a questionnaire to the respondent.

The following multilateral agencies were contacted through officers handling health matters.

- (i) UN Agencies; WHO, UNDP, UNICEF, UNFPA and the World Bank
- (ii) European Union

Interviews with officers from the multilateral donors such as WHO, UNDP, UNFPA, WB revealed that these agencies supported research activities in operational health mainly by channelling resources through the public institutions such as NAC, MFONP, MOH or CBOH. It was the view of some multilateral donor agencies that much detailed information on research could be obtained from the institutions/individuals that they often commissioned to conduct health research. Table V, shows researches/surveys commissioned by multilateral agencies as obtained from the researchers records.

Bilateral Donor Agencies

The Bilateral donor agencies do play a very major role in the Zambian health delivery system in supporting various health programmes and in systems development. Bilateral donor agencies undertake and fund certain programmes jointly. They further play a vital role funding national activities such as the Zambia Demographic and Health Surveys (ZDHS) conducted by the Central Statistics Office (CSO), HIV and AIDS Sentinel Surveys among pregnant women, conducted by the Central Statistics and Tropical Disease Research Centre (TDRC).

Discussion with bilateral such SIDA, JICA, DFID, CIDA revealed that, like the multilaterals, they commissioned health research in close collaboration with MOH or CBOH who could then identify and fund an institution to carry out research (SIDA). Some bilateral organizations supplied reports of what they are involved in such as SIDA, JICA. The Bilateral donor agencies do commission greater part of their research activities by supporting the MOH in conducting joint reviews, monitoring & evaluation and surveys. They also undertake research activities through funding institutions and individuals including NGOs involved in research activities. The following bilateral agencies were contacted; SIDA, DFID, GTZ, CIDA, USAID and JICA

Non-Governmental Agencies (NGOs)

Zambia is home to many international NGOs. Invariably, all of them are involved in research of one type or another. Responses from many of them are yet to be received. The interviews with international NGOs showed that they did conduct health related researches in form of assessment surveys and monitoring and evaluation. Their activities were programme linked.

The NGOs based in Zambia are involved in numerous health researches. Majority of them are funded by donor agencies, largely from mother country. Most NGOs do directly undertake researches/surveys especially in form of assessment prior to project implementation. The following NGOs were approached; SHARE, JHPIEGO, AFRICARE, OXFAM, HSSP, SFH, CARE INTERNATIONAL, ZAMBART, CHESSORE, CHAZ.

Public Institutions Involved in Research Activities contacted

International donor agencies, commission research activities through specific public institutions that conduct health related research. Contact was made with the following institutions; University of Zambia, Department of Economics, University of Zambia, School of Medicine-Community Medicine, National Malaria Control Centre, Ministry of Health and Central Board of Health.

The questionnaire was served on both multilateral, bilateral agencies and NGOs either directly or through e-mail. None of the multilateral or the bilateral agencies with the exception of JICA responded to questionnaire. Only one NGO, Africare, did respond to the questionnaire. The main findings were that all health research has been funded by the international donor agencies while the NGOs including public research institutions have been conducting health research.

A total of twenty five organizations were served with questionnaires. Out of these only 8 (32 %) responded to the questionnaire, of which 6 (75%) were implementing institutions, One (12.5%) bilateral agency and one (12.5%) international NGO. No private for profit was highlighted as being supported to conduct operational research. On average the institutions who responded to the questionnaire had 7 research projects per institution.

The reports on health research conducted were submitted by research institutions and by some donors. The institutions included University of Zambia – Department of Economics and Department of Community Medicine, National Malaria Control Centre, Church Health Association, Centre for Health Science and Social Research, ZAMBART project, Africare, Zambia National Response to HIV and AIDS (ZANARA Project) in the Ministry of Finance and National Planning, Central board of Health/Ministry of Health and Central Statistical Office. The donors included, CIDA, SIDA, UNFPA, JICA and the World Bank. The papers were then analysed as to who sponsored them, at what cost, stage execution, and the impact made to the health sector. The researches were further classified in into four arbitrary groups.

| TYPE OF AGENCY | No. SUPPORTED | PERCENTAGE |
|-----------------------|----------------------|-------------------|
| Multilateral | 13 | 24.1 |
| Bilateral | 22 | 40.7 |
| NGOs | 06 | 11.1 |
| Others* | 13 | 24.1 |
| Total | 54 | 100 |

Table I: Number of Researches Supported by Different Agencies the pastFive Years

| NAME OF AGENCY | NUMBER SUPPORTED |
|-----------------------|-------------------------|
| CIDA | 2 |
| DFID | 9 |
| GFATB | 7 |
| IDRC | 2 |
| JICA | 2 |
| SIDA | 10 |
| UNDP | 0 |
| UNFP | 1 |
| USAID | 1 |
| WB | 6 |
| WHO | 5 |
| JOINT | 2 |
| OTHERS | 11 |

Table II: Number of Researches Supported by Various Agencies

A total of 54 operational research projects conducted between 2001 and 2006 were submitted either submitted as reports or by completing the questionnaire. These were classified into Public Health 21 (38.9%); Clinical Care 4 (7.4%); Health Systems Development 21 (38.9%); Monitoring and Evaluation 6 (11.1%); and 2 (3.2%) were classifies under others. The approaches of studies were qualitative and quantitative. Out of 54 research projects submitted 13 (24.1%) were funded by multilateral donors, 22 (40.7%) by the bilateral donors 6 (11.1%) by NGOs and 13 (24.1%) by other organizations and financing institutions.

| AREA OF FOCUS | No. OF RESEARCHES | PERCENTAGE |
|-------------------------|--------------------------|-------------------|
| Systems Development | 21 | 38.9 |
| Public Health | 21 | 38.9 |
| Clinical Care | 4 | 7.4 |
| Others | 6 | 11.1 |
| Monitoring & Evaluation | 2 | 3.7 |
| Total | 54 | 100 |

Table III: Focus of Researches Undertaken Past Five years

Despite the fact that a lot of research is being undertaken, there still remain a gap between linking research to policy and implementation. Out of the total researches submitted, 29 (53.7%) have been completed and are in use. Out of these 9 (16.7%) have influenced policy development and 21 (38.9) have influenced program implementation. Two projects though completed have not had any influence on policy or program implementation. Five (9.3%) research projects were completed but not in use, 4 (7.4%) have not been disseminated, while 16 (29.6%) are still on going. It was interesting to note that only two Institutions University of Zambia – Department of Economics and the ZANARA project indicated their annual research budget. Of the nine projects which were completed and in use, 3 researches that focused on public health and 6 on health systems development influenced policy development, while 11 studies that focused on system development and 10 on public health had an impact on program implementation.

| STAGE OF IMPLECATION | No. RESEARCHES | PERCENTAGE |
|-----------------------------|-----------------------|-------------------|
| Completed and in use | 29 | 53.7 |
| Completed not in use | 5 | 9.3 |
| Not Disseminated | 4 | 7.4 |
| On Going | 16 | 29.6 |
| Total | 54 | 100 |

Table IV: Status of Research In Implementation

SYNOPSIS OF RESEARCH REPORTS COLLECTED

This section gives brief description of some of researches commissioned and/or undertaken by various donors and NGOs.

National Health Accounts 1999 – 2002

Author(s): University of Zambia, Department of Economics

Introduction: The National Health Accounts (NHA) have been defined as a comprehensive compilation of data on sources and uses of a country's spending on health, giving both an aggregated and disaggregated picture of the expenditures. The NHA describes who spends, how much they spend and on what type of health services they spend. It is a tool designed to inform the health policy process, that is, planning, implementation, dialogue and monitoring and evaluation. The NHA, in combination with other non-financial data can be used to assess policy effectiveness.

Methodology: The NHA data in this report covers the period 1999 FY to 2002 FY.¹ The data comprises all expenditure whose primary purpose is to restore, improve and maintain health. The main sources of data are government institutions, donors, statutory bodies and boards, private health providers and households. These institutions incur or in one way or another contribute to health expenditures. Since data was collected from diverse sources, the study employed both secondary and primary data collection methods. In the government sector data was collected mainly from audited financial reports and other government financial books and records on government releases. Most of this data was readily usable and did not require any adjustment. In order to facilitate triangulation, a survey of statutory bodies and boards was carried out to determine their sources of funds and how they spent these funds. Data from donors was collected at financing agent and provider levels such as MOH, CBOH, statutory boards and bodies. However, data collection was not done at donor level due to limited resources. Public enterprises' health expenditure, which largely comprised ZCCM was collected from financial reports at headquarters. In addition, a ZCCM health facilities study was conducted to determine the sources of funds and how these funds are distributed. Health expenditure by NGOs was collected at financing agent level and at facility level for those NGOs that receive money from the government. Therefore, data from other NGOs was not captured and thus NGO health expenditure is underestimated. Private firms' expenditure was collected from health facilities at provider level which are either run by the firms themselves or at which they pay for health services for their employees

Conclusions and Recommendations: The Study shows that while total health expenditure increased more than five-fold between 1995 and 2002, it remained stagnant in real terms. Thus the increase in health expenditure has only been enough to cover price increases and not an increased level of health services. Total per capita health expenditure ranged

¹ A Financial year in Zambia runs from January to December

between US\$ 20 and US\$ 25 over the period under consideration. This is far below the minimum amount required to finance the Basic Health Care Package. Government expenditure on health as a percentage of total government expenditure has remained below 15 percent commitment of the Abuja and Maputo declarations.

The study shows that the share of household expenditure in total health expenditure though falling over the period, has remained very high. Given that these expenditures are in the form of out-of-pocket this indicates that many households are being exposed to catastrophic spending and therefore falling deeper into poverty by seeking health care. There is need to address this catastrophic spending by households either by increased provision of government health services or by some form of risk pooling mechanism of household resources or both, so that Households are not exposed each time they have to seek health care. This has implications on both access and equity of health care. The pattern of resource allocation among different levels of health care showed that substantial resources were still being allocated to secondary and tertiary levels compared to the primary level though in the later years of the study a reversal of this pattern was becoming evident. This shift has to be sustained so that the disease burden can be addressed at the point where the impact is greatest.

The study reveals the importance of the role of the private sector in the provision of health services. More than 90 percent of out-of-pocket spending by households flow to the private sector in form of user fees and purchases of drugs and other pharmaceuticals. Thus, there is need for government to put in place deliberate policies that forge strong partnerships with the private sector to influence it in a manner that leads to the achievement of the goal of providing quality, affordable and cost effective health care as close to the family as possible.

Some recommendations of this study have influenced MOH recent policy announcements such as user fees at rural health centre level. Currently efforts are being made to institutionalize the NHA system in the Ministry of Health (MOH). The institutionalization process involve having specific personnel assigned to maintaining the NHA system as their day-today duties and the transformation of the way data is reported to MOH/CBOH by the hospitals and districts into the NHA format. There is also continued sensitization of the policy makers of the existence of the NHA system and its policy relevance.

Factors Associated with Correct use of Anti-Malaria Drugs in Two Selected Districts in Zambia

Author(s): Dr. S.N. Kanyimba, Lecturer, School of Medicine, University of Zambia; Dr. L.T.M. Muungo, Lecturer, University of Zambia

Background: Results from previous studies on use of anti-malaria drugs suggest that a large proportion of people who take anti-malaria drugs take them incorrectly

Main objective: The general objective of the study was to determine the factors that are associated with incorrect use of anti-malaria drugs in the community, in order to help policy makers to devise strategies that would improve the rational use of anti-malaria drugs in Zambia.

Methods: A cross-sectional survey was conducted in Livingstone and Monze districts of Southern Province in Zambia from 16th August to 7th October 2003. Household surveys in the community involving eight hundred and fifty seven (857) participants who had an episode of malaria in the previous two weeks. The study also used patient exit interviews involving 371 patients at government health facilities who had been diagnosed to have malaria. During the household surveys, the focus was on the anti-malaria drugs that the subjects had taken and how they had taken them, examined the dispensing practices of the healthcare providers at the health facilities during the patient exit interviews.

Results: The frequency of taking an incorrect total dose was 35.3% with sulfadoxine-pyrimethamine (SP), 40.8% with chloroquine (CQ) and 86.4% with quinine (QN). The frequency of taking an incorrect total dose of SP was higher in children (77.4%) compared to adults (12%). The drugs were administered at a wrong frequency and for a wrong duration in a number of cases: SP – 1.5%, CQ – 9.5% and QN – 47.8%. The factors identified to be significantly associated with incorrect SP dosing are lack of knowledge of the SP dose (RR=2.09; CI: 1.70 to 2.57) and inadequate labelling on drugs (RR=2.24; CI: 1.24 to 4.07).

Conclusion: The study confirms that there is a high frequency of incorrect dosing with anti-malaria drugs. Two factors have been identified to be significantly associated with incorrect SP dosing: lack of knowledge of SP dose and inadequate labelling of drugs.

Recommendations: (1) Good prescribing and dispensing practices by all health workers (2) Information on dosing of anti-malaria drugs should be given to patients (3) Administration of SP to children should preferably be done under supervision of health workers (4) Only qualified personnel should prescribe and dispense anti-malaria drugs

Survey on Drug use in various Communities in Lusaka, Central and Southern provinces of Zambia.”

Dr. S. N. Kanyimba, Lecturer, Pharmacology, University of Zambia.

Background: A number of studies done all over the world; indicate that irrational use of drugs is common in many communities. Studies that were done by Evelyn Hone College Pharmacy Technology final year students in 1998 to investigate drug use in various Health Centres in Lusaka suggest that irrational drug use is widespread.

Forms of drug misuse in most studies include; failure to comply with prescribers' prescriptions, self medication with prescription drugs, misuse of injections, use of inessential drugs, use of needless expensive drugs, over-use of some commonly used drugs

It is against this background that a study was conducted to investigate the way drugs are utilized in a number of communities in Zambia. A survey of drug use will help to identify the forms of drug misuse that are common and what factors underlie irrational drug use. The results of the study would help health researchers to design appropriate intervention studies and assist health planners in the development of strategies to change drug use patterns so that drugs are used rationally. Further, these results will be presented to health educators in various institutions training health workers and to health planners in the Ministry of Health/Central Board of Health. This will help the health educators include principles of rational drug use in their curricula so that the health workers trained graduate with knowledge of good prescribing and dispensing practices.

Objective: To study drug use patterns in various communities in order to determine the magnitude and nature of irrational drug use, and recommend measures that will promote rational use of drugs.

Methodology: Study Type: Descriptive Cross-sectional Study, Sample Size: The study covered 18 health centres in Lusaka (10), Central (4) and Southern Provinces (4). A total of 1499 households in the communities served by the selected health centres will be surveyed. 30 community health workers connected to the selected communities will be interviewed. The study was done from December 1999 to March 2000.

Conclusion: The study has shown that irrational drug use exists in Zambia. It has been found that there is excessive use of antibiotics. There are drug shortages in most health facilities and most patients cannot afford the costs of drugs. Most health workers involved in prescribing and dispensing do not have access to latest information on drugs. There are hardly any personnel with training in pharmacy at the health facilities. The work of pharmacists, pharmacy technicians/technologists and dispensers is mainly done by nurses.

Recommendations: It is recommended that the training of clinical officers, nurses and community health workers be improved to cater for their expanded roles. Health workers should regularly attend refresher courses and seminars to have their knowledge and skills

on drug use up to date. Essential drugs should be available in health facilities at all times. Activities to promote rational use of drugs should be increased.

Assessing Quality of Responsiveness of Health Services for Women in Crises Settings

Author(s): Dr. Likwa Ndonyo, Lecturer, School of Medicine, Department of Community Medicine, University of Zambia.

Background: Zambia being one of the countries in Southern Africa, with the poorest socio-economic indicators and the highest disease burden in Sub-Sahara Africa has an ambitious Structural Adjustment Programme that lays foundation for the Health Sector Reforms. The goal is to provide Zambians with equitable access to cost effective quality health care to the family as possible. The emphasis has been on decentralization and integration of health services, which is build on sustainability, leadership, accountability and partnership (SLAP) in health. Despite this effort, the health sector still faces great challenges of its economic deprivation resulting from high burdened diseases, such as HIV/AIDS/TB, malaria, high maternal and child mortality consequences, coupled with poverty and poor governance.

General Objective: Assess quality and responsiveness of health services for women in urban rural population in Zambia

Methodology: A measurement tool was developed to identify and define operational variables for measurement to address issues focusing on national legislation measures, health and social service strategies and plans. Other components involved estimating effectiveness and efficiency of health systems; quality of health care provision in health facilities; and physical access barriers, and affordability of health services (socio-economic status). Social cultural dimensions and prevalence of sexual and gender domestic violence among women are some of measurements included in the assessment tool. A total sample of 206 was achieved from different study populations. The assessment was conducted in two different geographical settings in Lusaka Urban and Katete districts. Respondents were recruited in the study using quota sampling method and simple random procedure. A mixed research method employing use of quantitative and qualitative methods was applied to yield data. These include, structured interview questionnaire for households, exit interviews, health provider's questionnaire, Checklist for health facility assessment, focus group discussions and semi-structured interviews for key informants including programme managers and policy makers.

Results: The review shows that access to quality and responsiveness to health services for women in Zambia is still problematic in different geographical settings (i.e. urban and rural). This has been coupled with weak law enforcement for social service support, unclear policy guidelines impinging on health services for women; non-availability of strategic plans to recognize the importance of gender and health in national health plans; and cost of services along side with physical barriers, such as distance and transport system.

Recommendations: Restructure the health facilities, improve condition of service for frontline workers, expand development of health posts in rural and peri-urban areas are essentially to reduce health centre work-load and increase accessibility to health services for women, equip health facilities with adequate equipment, supplies and transport system for emergencies, enhance ethical professional conduct of health providers, strengthen In-service training in current aspects of reproductive health matters, family planning and sexual and gender violence, to include civic education are vital to build capacity among health providers, encourage participation in decision-making process on issues affecting health services for women, expanded training programme for traditional birth attendants and community volunteers in integrated management of pregnancy and child birth to include family planning, HIV and AIDS home based care, civic education and enhance collaboration links with health providers are essential components of strengthening human resource capacity at a local level, strengthen antenatal and postnatal care at community level, review policies that affect women’s health and rights, adopt gender-based resource allocation, mainstream gender into Plans, health data be disaggregated by gender to determine service impact and outcomes, redefining and development of guidelines for the provision of safe abortion services to suit the needs of women, Adolescent Health Services to be supported by policies and guidelines including free health services for adolescents and children below 14 for urban and rural populations, advocacy- through women forum/for civic education to be intensified, assessment findings yield series of research areas related to policy analysis, abortion, sexual and gender-based violence, and adolescent health.

**Governance, participatory mechanisms and structures in Zambia’s health system:
An assessment of the impact of Health Centre Committees (HCCs) on equity in
health and health care**

Author(s): T. J. Ngulube, Laxonie Mdhluli, Khuzwayo Gondwe, C.A. Njobvu

Background: In 1992, the Zambian government had introduced country-wide health reforms in the public sector. Between 1994 and 1998, CHESSORE undertook a 2-phased study to monitor and evaluate the implementation of the Zambian health reforms, with a view to identify good practices, bottle necks and feed information into the implementation process for better outcomes. The key features of the reforms were centred on the core principles of leadership, accountability and partnerships at all levels in the health system. Around these core principles, implementation strategies were developed with the objective to attain the reform vision “to provide equity of access to cost-effective quality health care as close to the family as possible for all Zambians”. At the lower level of the system, the implementation of the core reform principles were to be attained through the creation and activities of health centre committees (HCCs) at health centres; supported by activities of community based health volunteers [the neighbourhood health committees (NHCs), community health workers (CHWs) and traditional birth attendants (TBAs)]. This study undertaken by CHESSORE, as part of a

collaborative multi-country study through EQUINET was designed to assess whether these perceptible positive gains were sustained; and if so, what factors contributed to this outcome. In addition, the study compared the performance of these four 'successful' HCCs with four poorly performing HCCs in districts with matching socioeconomic characteristics. The study also sought to identify the ideal desired features to successful community participation in the Zambian health system.

Objective: This study re-examined these issues by following up and comparing the performance of the four 'high performing' HCCs identified in earlier studies with four 'low' performing HCCs.

Methods: Using a semi-structured questionnaire, along with key in-depth interviews, PRA tools, stakeholder workshops, outcome mapping techniques and the collection of available data at health facilities. A sample of 574 community interviews were undertaken, with 47 in-depth interviews, 35 key informant interviews, a stakeholder workshop, and 10 PRA sessions. To assess the impact of HCCs on the poor and vulnerable groups in the community four special group discussion sessions were held with representatives from marginalised groups (widows, orphans, the disabled and the elderly). The data was captured and entered into the SPSS computer statistical software package for storage and analysis. This data was analysed by frequencies and cross tabulation of variables. The EPIInfo statistical software package was used to assess for significance in outcomes between variables. Group discussion sessions were tape recorded, transcribed, typed and stored in Microsoft word software package. The group discussion data was later analysed grouped into key theme areas of concern to equity and by the vulnerable groups.

Findings: The HCCs were still in existence at all sampled health facilities. Those that performed well during the earlier survey had continued to perform well, despite facing challenges such as hostility from the health system. The innovations introduced were still in place and functioning. However, on average HCCs were known to no more than 20% of community residents. HCCs were better known among the less poor socioeconomic groups than among the poorest groups in society. The better performing HCCs were also performed well with respect to participation in decision making, priority setting, monitoring expenditure and quality of services. Some HCCs had acquired authority to make own decisions on certain things. The better performing HCCs kept their user fees lower and provided for other alternatives to cash payments than the poor performing HCCs. All key stakeholders at district level, whether from HCCs, frontline health workers and from the DHMT were unanimous to say that HCCs have made an impact and their value to the health system was acknowledged. However, this impact was limited in terms of the desired equity goals and coverage. There was consensus too that HCCs had little or no impact among vulnerable groups and in important decision making roles at the health centre, especially in relation to clinical care services. Channels of communication have been developed between the health system and HCC in health promotion and provision of preventive services. Even then, there were still problems in the flow of information, which was usually one way from the health system to communities, with feedback being rare infrequent and ineffective. From key informant

interviews, which included HCC members, the view was that the HCCs were now an accepted part of the health The lack of guidance in this respect is manifested by little knowledge among community respondents on things such as tenure of office for HCC members, procedures for removal from office and other democratic values necessary for greater transparency, accountability and responsiveness

Conclusion: In conclusion, the HCCs have assumed an increasing role and with increasing importance to all stakeholders for their roles and function in highlighting health problems in the communities in Zambia. This is recognised as such by all stakeholders at district level health services. It is also recognised that these structures of community participation are having an effect on the delivery of primary health care services, at least at the local level.

Understanding HIV and TB Stigma and Resulting Discrimination in Ethiopia, Tanzania and Zambia, November 2001 to November 2003

Authors: International Centre for Research on Women, Washington, Zambart Projec, t Kara Counselling and Training Trust, Virginia Bond.

Objectives: To understand the causes, manifestations and consequences of HIV and AIDS- related stigma and resulting discrimination in Sub-Saharan Africa, To recommend programme interventions to reduce stigma and discrimination related to HIV and AIDS,

Methodology: Two sub-studies in Zambia aimed to:

Results: Most of the time, stigma is directed at people who are assumed to have HIV and AIDS and who often do not know themselves what their status is; A significant proportion of discriminatory actions are caused by the fact that HIV and AIDS is hard to manage in the context of poverty. Women, orphans and rural areas are especially vulnerable to poverty-related stigma; There was less stigma in the urban site than in the rural site; this was due to more in-depth knowledge, and, a much greater range of sources of information and special services for PLWHA and orphans in the urban site; The main causes of stigma relate to incomplete knowledge, fears of death and disease, sexual norms and a lack of recognition of the impact of stigma; Stigma impedes various health interventions, including the diagnosis and treatment of opportunistic infections and testing, disclosure, prevention, care and support for PLWHA; Experiences of stigma are determined by different situations, settings and stages of the disease; Many people living with HIV and AIDS internalize stigma, and this can result in depression, premature death and suicide. Secondary stigma is widely experienced by families and children; Care and support co-exist with stigma.

Recommendations: Support programmes that address poverty, rural deprivation and the rights of women and children; Conduct anti-stigma education for PLWHA, orphans, TB patients, affected families, NGOs and CBOs, FBOs, health care institutions and the

media. An anti-stigma education training manual was developed across the three countries; Foster in-depth, applied and up-to-date knowledge about all aspects of HIV

Care Moyo wa Bana Project Survey

Author(s): Care International in Zambia and Care Canada

Background: Zambia's population is estimated to be 9,869,695. An estimated 20% are children under the age of 5 years. Child mortality for the 1997 to 2001 period was 168 deaths per 1000 live births, while the infant mortality rate stood at 95 per 1000 live births². This indicates that more than 50% of the deaths occur during the first year of life. The top five main causes are malaria, diarrhea and acute lower respiratory infection (ALRI). In order to supplement the efforts of the national health system, CARE International is implementing through its Moyo Wa Bana project a series of promotive, preventive, and curative interventions in order to improve the health of the Zambian child. This project also provides integrated care in health centres, communities and households. Through building capacities of health workers and community-based agents, quality health care is delivered appropriately to families.

Zambia is among the Southern African countries with very high HIV and AIDS prevalence. According to the 2001/2 DHS, it is estimated that prevalence among the 15-49 year age group is 16%. Further, in the Global Report on the AIDS Epidemic, UNAIDS reports that 22.1% of pregnant women aged between 15 to 24 years tested during antenatal visits in Lusaka in 2002 were found positive. Approximately 39.5% of babies born of HIV positive mothers are at risk of being infected with the virus.³

Objective: To assess the progress made in achieving the programme results and document change(s) among the caretakers in knowledge and health seeking behaviour

Methodology: Mixed method of approach was taken in collecting both quantitative and qualitative data. The project areas were stratified into two categories:- rural and urban. Lusaka and Ndola were taken as urban districts while Kasama as a rural district. Eleven health centres were looked at in Lusaka, Eight in Ndola district and nine in Kasama district. The study area stratification was taken in order to ascertain if urban/rural location played any role in achieving results.

Results: The study has shown that strategies being used in the project are bearing positive results at both clinical and community levels because; there is some reduction in rates of the three targeted diseases among the under fives in the project areas, Malaria has

² ZDHS of 2001/2

³ National HIV/AIDS/STI/TB Strategic Plan, 2002

reduced from 41% to 32%; diarrhea from 46% to 31% and pneumonia from 12% to 7% in the two weeks preceding the survey, Caretakers have improved in their level of knowledge on identification of their children's health needs and in their health care seeking behavior, Eighty five percent (85%) of caretakers had taken their under five children to the monitoring points, About 90% of caretakers were able to correctly identify the management of children with diarrhea, and 76% reported correct way of s of preparing ORS at home and almost 89% reported correct signs of pneumonia in children, The proportion of children who registered under weight has dropped from 28% at baseline survey in 2002 to 20%, On HIV and AIDS the survey found that; about 50% of caretakers are aware of the available IV/AIDS/STI and VCT services within their catchment areas, 85% of care takers had knowledge of at least 2 methods of HIV transmission, 83% had some good knowledge of preventive measures, On drinking water, 90% of respondents reported making drinking water safe by using chlorination and boiling methods, The survey showed that 41, 41% of households reported that they owned ITNs compared to 27% at baseline survey. Of these 98% availed the bed nets to their under five children compared to 29% at baseline.

Recommendations: Moyo Wa Bana must strengthen its efforts on the implementation of some activities identified as gaps in the project areas like Ndola, Health education relating to the three target diseases, environmental sanitation, HIV/AIDS and the quality of child health growth monitoring and promotion interventions must be strengthened

Rapid Socio-Cultural Research as a Methodology for Informing Sexual and Reproductive Health/HIV/AIDS Programming in North-Western Province, Zambia

Author(s): UNFPA

Background: The UNFPA missions in Zambia and the Government of the Republic of Zambia (GRZ) have developed a fifth country programme (2002-2006), whose main focus and area of implementation is North-Western province. The Government and UNFPA have established a set of inter-related service delivery and community-based reproductive health projects. These aim to strengthen and expand existing development programmes in the province in line with Zambia's population and reproductive health policies⁴.

North-Western Province is the third largest province in Zambia. Just under 6% of population lives in this province whose annual growth is estimated to be a little under 3%. Majority of people live in rural areas. It is sparsely populated at fewer than four

⁴ Reproductive health includes-adolescent sexuality, family planning, sexual transmitted infections (including HIV/AIDS), pregnancy and birth, post-abortion care, and gender relations

people per square kilometer. The fertility rate is 6.6 with at least half of the women marrying and giving birth in their late teens.

Mortality levels are rising. The under five mortality rate increased from 95 deaths per 1000 live birth in 1980 to 126 deaths in 1990 and 137 in 2002⁵. Life expectancy at birth is dropping too, from 57 years in 1980 to 51 years in 1990.⁶ HIV/ AIDS prevalence is estimated at 9%, which is one of the lowest.

Overall Objective: To use information obtained from SCR to inform programmatic interventions

Methodology: Semi-structured interview guide- to be used with groups of informants. A set of interview guides were developed before the study. Focus group discussions, each involving 10-12 participants. Collection of qualitative information in the following subjects; knowledge of sexual and reproductive health, health seeking behaviour and health facilities, cultural practices, sexual behaviour, gender and sexuality, STIs/HIV/AIDS, Fertility, family planning and safe motherhood, Source of sexual and reproductive health information, and how this subject is taught

Results: The study presented the result findings *as* per subject of focus below:

- a) *Knowledge of Sexual and Productive Health-* It was found that most the most of them could recognize and distinguish signs and symptoms of different STIs. They usually relied on traditional remedies for treatment because the few health facilities are far and poorly equipped and staffed.
- b) *Health-Seeking behaviour and Health facilities-* Study found that user fees were disincentive to facility utilization. Health facilities run by catholic missions shunned because of policy on contraception. Knowledge of poor facilities/staff at a health institution discourages utilization by communities.
- c) *Cultural Practices-* Some ethnic groups (Kaonde and Lamba) are abandoning deleterious (to health and gender stereotyping) traditional practices such as initiation at puberty, circumcision (hygienic reasons), girls develop less interest for school after initiation. Those still practicing, the initiation ceremony is shorter. Ritual sexual cleansing not practiced among Luanda and Luvale, but still practiced by Kaonde and Lamba-though at times without sexual intercourse.
- d) *Sexual Behaviour-* It was found that sexual activity begins early. Unprotected sex is rampant. There exist practice of abortion using unsafe and dangerous methods. While condoms are known by all groups, people do not like using them even though they know they prevent STIs. Dry sex is commonly practiced. While it was said that polygamy is not common, sex with multiple partners is common despite being aware

⁵ CSO 2003

⁶ CSO 2003

of attendant health risks. It was found that there is wide spread relationship between male teachers and female pupils at times welcome by girl's family.

- e) *Gender and Sexuality*- Gender stereotypes are adhered to. Most respondents were clear of different roles and rights for men and women. There is common belief that man might use either psychological or physical violence on the wife. Rape and child abuse matters are usually dealt with by traditional means rather than the courts.
- f) *STIs/HIV/AIDS*- There was reasonably accurate knowledge of STIs. Treatment is first sought from traditional healers and resort to modern medicine only if problem persists. There is high awareness of HIV. Condoms are not commonly used by many couples (believed to signify lack of mutual trust between spouses).
- g) *Fertility, Family Planning and Safe Motherhood*- There was a belief that infertility is exclusively female problem. There is recognition of child spacing. Women rarely give birth at clinics or health centres. Sparse spacing of health facilities, makes pregnancy a risky occurrence. Most women do not use clinics either because they are far or in most cases the midwife is male.
- h) *Sources of Sexual and Reproductive Health Information*- The study showed that most information is obtained from peers. This is supplemented by relatives such as aunts, uncles or grandparents. It was found out that some teachers found it difficult to broach these matters. Modern media are not accessible in most areas.

Zambia Health Facility Census 2005-Preliminary analysis and feedback at a Seminar held ON 13TH December 2005, Lusaka, Zambia

Author(s): MoH and JICA

Background- Government of the Republic of Zambia in conjunction with cooperating partners has embarked on a census of health facilities throughout the country. The census will take count of health infrastructure, plants, equipment and instrumentation, utilities and human resource. On a seminar held on 13th December, 2005, a preliminary report was unveiled.

Objective: To provide evidence for policy, planning and development of health services. To determine conditions and coverage of physical infrastructure for health service delivery system. To determine the level of availability of medical equipment for the delivery of the basic Care Package and ARVs. To determine the availability of transportation and communication facilities for the basic health care package. To determine the conditions and availability of drug storage facilities

Methodology: The exercise will involve physical inspection of all health facilities, focus on infrastructures and utilities, Additional information on human resources and services. The census will include; (i)Service Available Mapping SAM (key informant interview at district level, rapid data collection, use of PDA, availability of services) (ii) Service Provision Assessment (SPA/HIV) in Zambia such as Sample survey of health facility and Quality of HIV/AIDS services. The Census is targeting the following facilities, MOH, 2002, review by PHO and DHMT, government and government affiliated mission and private facilities, Defense and Prison facilities excluded for security reasons ((GPS data, Health Post, health centre, 1st level hospitals. The following main data items are to be captured, Geographical location, General information, type, ownership, catchment population, Physical infrastructure, Utilities including: water, electricity, waste management, Fire fighting, Communication, transport, Medical equipment, Human Resource: Headcounts of selected types, Health Services: Maternal Health, Child Health, Family Planning Services, Malaria, STI,HIV/AIDS, TB, Water & Sanitation, Food & hygiene, and control of infectious diseases.

Preliminary Results: - so far have produced, Type and ownership, GPS-distribution, and physical accessibility, Availability of utilities, Health services, Human resources- nurses, General information such as:- facility ID, Ownership, Facility type, Catchment population estimated by CSO and other sources de

Issues/Recommendations: there is need to include private for-profit facilities, Defense and prison facilities without GPS data, Maintenance of the database, Linkage with HIMS, Classification of health services

Evaluation of Institutional Capacity Building of Health Economies in Zambia

Author(s): Bo Erlandsson, Veronica Gunnarsson

Background: The Department of Economics (DoE) at the University of Zambia and Swedish institute for Health Economics (IHE) have been collaborating in *health Economics research and health Policy analysis* since 1995. The collaboration has been under the SIDA. This has been to support Institutional Capacity development in Health Economies through Institutional Collaboration. The support is very closely linked to and channeled through the Ministry of Health.

Objective of Evaluation- The main purpose of the evaluation is to describe and assess the effects of the support on the capacity development in health economics in general and at the Department of Economics, university of Zambia, in particular. The evaluation was done between August and October 2005.

Methodology: Seminars- The evaluation process was done through a series of seminars in Zambia and Sweden. This was unique in that it was modeled in such a way that the participants/stakeholders in the evaluation projects actively took part. It was also a learning process and part of capacity building for the stakeholders. *Interviews-* A series of interviews were held in Sweden as well as in Zambia. A total number of sixteen interviews were held. *Literature Review-*This was done through review of relevant documents (work plans, financial reports etc)

Result: The study established that SIDA support has resulted into strengthened competence in several areas including; increased the in-house capacity at the Ministry of Health (MOH), Strengthening the Department of Economics, UNZA, Contributing to building of a critical mass of health economics in Zambia, Resulting in several policy-related studies, a few publications.

Recommendations: There should be created attractive and conducive environment at Department of Economics at UNZA in order to retains/attract health economics, There should be better relationship between DoE and MOH-The Ministry of Health should be regarding DoE more as a collaborative partner, The MOH should open up to the DoE, so that there is more academic –relevant issues between the two institutions, SIDA should continue strengthening the collaboration.

Coping with the impact of HIV and AIDS on Health Workers in Zambia: A pilot study in two districts

Author(s): Churches Health Association and Koninklijk Instituut Voor De Trpen Royal Tropical institute

Background: In countries hard hit by the AIDS epidemic, the increasing number of patients coupled with the increase in programmes to respond to the crisis is putting a very heavy burden on the health sector. Zambia is one the countries severely affected by the epidemic with a national prevalence rate of 16 percent. HIV and AIDS has had impact on the type of service delivery and the workload on health workers although little data exist. An exploratory qualitative study into the current coping mechanisms of health workers was in relation to staff living with HIV and the impact of caring for HIV and AIDS patients was conducted in Mpika and Mazabuka districts in October 2003 to provide information for policy planning for staff in areas with high burden HIV.

Objectives: (i)to describe the HIV and AIDS prevalence in the two districts and determine the services provided to mitigate the impact of HIV and AIDS (ii) to describe the productivity and use of HIV and AIDS services and their trend over the past five years (iii) to explore the perceptions of managers and health workers on the impact of HIV and AIDS in the district and how the impact of HIV and AIDS influences attitudes

to work, personal emotions, perceived work load, the type of services provided, the productivity of facilities and use of services (iv) to describe and compare the different factors related to the AIDS epidemic that influence staff in two districts in order to identify the staff availability and acceptability for service delivery to HIV and AIDS patients (v) to explore mechanisms for staff to change cope with these changes and the support offered by the health services (vi) to provide recommendations to policy makers and managers so they are better able to support health workers in dealing with HIV and AIDS at workplace.

Methods: The impact on health workers was explored by measuring availability for work and acceptability to work and identifying the variables and issues influencing this such as absenteeism or sick leave, burnout and motivation for work and by exploring the personal and organizational factors influencing motivation. Data was collected through interviews, focus group discussions and self administered questionnaire. In addition, a psychometric instrument to measure the burn out level of health workers was used, the Maslach Burnout inventory (MBI).

Results: Despite the large difference in prevalence rates (Mpika 8.3% and Mazabuka 23%), reactions to impact of the epidemic at district level were similar. The District AIDS Task forces coordinate the different activities to mitigate the impact at district level. The quality of HIV and AIDS activities is not ensured due to staffing and service related problems. AIDS affect service delivery in many ways; increase in workload due to extra tasks and a higher number of consultations, Fear of infection at workplace. Very few worker use post exposure prophylaxis services. Combination of problems at home and increase workload in the workplace places the staff at high risk to stress. The MBI showed the nurses and counsellors are at high risk to emotional exhaustion. The study showed lack of staff, support, low salaries, equipment, and poor incentives. Mangers had difficulties in solving these problems within limited budget and support.

Conclusion: Many of the study findings are confirmed from results form other studies. The results show most staff are emotionally exhausted despite feeling compassion for their patients. Various coping mechanisms are suggested, such as peer exchange, professional supervision, improved task preparation through training, tress reduction management, developing and implementing a work place policy and program to ensure protection, care and support for staff living with HIV.

Recommendations: (a) Better registration of absence and attrition of staff (b) development and implementation of work place policy and program (c) Training and support of managers in implementation of programs ((d) development of innovative strategies to improve working conditions of staff (address staff shortage, low salaries and incentives and lack of support and supervision) (e) Conduct research t provide evidence based

Rapid Assessment on the Home management of Malaria in Zambia: The Caretaker and the Community Health Worker.

Author(s): Pascalina Chanda, Hawela B moonga, Dr Naawa Sipilanyambe

Background: The community is an important segment of health care delivery. It is the first point of contact for malaria case management. In an effort to improve access to effective treatment, consideration is being made to develop and implement a sustainable home management of malaria strategy. A rapid assessment was conducted in November 2004 to collect data on the knowledge, attitudes and practices in districts which were the new drug policy with ACTs was to be implemented first. This was done to generate information needed to understand what is pertaining on the ground to help develop a strategy for implementing home management of malaria in Zambia.

Methods: A cross sectional descriptive study was conducted in six districts in Zambia. A semi structured questionnaires was used to collect data from caretakers (N=1322) and community health workers (N=67) using the community health workers manual as yard stick for correctness of knowledge and practices. Field observations of community health workers were also made to enable a field assessment.

Results: The knowledge in the caretakers with regard to recognition of signs and symptoms of simple and severe malaria was found to be 89.9% and 65.6% respectively. In the event of child high fever, 71% of respondents said they would take the child to the clinic first, 25.5% use tepid sponging or antipyretic at home, 6.3% said they would take the child to community health worker while 3.3% would either treat with anti-malarial at home or use traditional Medicine. Community Health workers were found to keep good morbidity data and were knowledgeable with management of both simple and severe malaria.

Conclusion: Both the community and community health workers have sufficient knowledge, the practices could be improved upon and thus provide access to early recognition and prompt treatment. Mothers were the main caretakers for sick children and may thus play a complimentary role with community health workers in implementing the home management strategy.

A pilot study of HIV and AIDS and Health Systems in Zambia: A Country report

Author(s):Caesor Cheelo, Jesper Sundewall, chris Phuka and Felix Masiye

Background: The country report is based on a coordinated research work that was undertaken in Zambia (concurrently with South Africa and Tanzania) under a three pilot study during the second half of 2005. The Zambia component of the study sought to gain insight into the functioning of the health system in Zambia. The aim was to understand how the health system in Zambia is operating in the advent of HIV and AIDS pandemic taking on board the confounding effects of decentralization and multisectoral approach.

Research Aims: To develop an understanding of how (i) the public health services in South Africa, Tanzania and Zambia are functioning in the context of HIV and AIDS (2) Public health care delivery is managed in these countries

Methods: The study focused on three themes of health systems i. e. structures/frameworks, decentralization, and donors/partners that partners identified as principal areas to examine. The instrument of data collection was a semi-structured questionnaire. Information was collected from various institutions involved in the fight against HIV and AIDS at national and district levels.

Results: At the central level the structures and institutional frameworks are quite explicitly defined i.e. CBoH is the main implementing for clinical programmes including ART while NAC is the main body in charge of coordinating and monitoring the multisectoral response to HIV and AIDS. The relationship between CBoH and NAC remains unclear. Similarly the relationship between hospital and district health boards remains unclear. These unclear relationships undermine the effective programme implementation.

The HIV AIDS Structures at local level, the District AIDS task forces and the provincial AIDS taskforces require more definition in their terms of reference, guidelines on procedures and communication mechanisms. Study showed limited understanding and knowledge regarding integration of hiv and AIDS in the public health care system in Zambia.

Recommendations: Further study on (i) Management of HIV and AIDS under SWAP mechanisms looking into programming and joint financing issues. (ii) Factor influencing donor decisions to adopt a more vertical or more integrated approach in their assistance (iii) How special initiatives for HIV and AIDS can be included within the larger SWAp process in Zambia..

Pilot Survey of Private Health Care Providers In Lusaka District

Author(s): Webby Wake, Chris Mwikisa, Jesper Sundewall, Birger Forsberg

Background: The role of the private sector in the delivery of health services is increasing becoming significant. In Zambia, private clinics have increased from 150 in 1994 to 440 in 2003. Similarly, the number of private hospitals increased from 2 to 21 during the same period. The purpose of the study was to enumerate private health providers, access their capacity and competences as well as review the existing regulation framework within which they operate.

Objectives: (1) Describe and enumerate health facilities in Lusaka (2) test the relevance and feasibility of research instruments on a selected sample in Lusaka before being applied in the main study of private health sector in Zambia.

Methods: The surveys covered three types of respondents: private providers, exit clients and households. Structured protocols and questionnaires were used in interviews.

Conclusions: Private hospitals though small provide wide range of services, most have limited diagnostic facilities, employ qualified personnel and are regulated by government. Collaboration between private and public hospitals is mainly through referrals. Majority of pharmacies in Lusaka are private, fully registered and well stocked with drugs, dispensing drugs on prescription. There is limited collaboration with government health facilities. The pricing of drugs varies from pharmacy to pharmacy. The traditional health practitioners provide services to less educated people on selected ailments. Majority of them are aware of government regulation and are inspected by their associations and would like to work side by side with the western trained doctors in public health facilities.

Recommendations: Creation of enabling environment for continued growth of the private sector to deliver health services and for public and private to work and collaborate together by providing incentives and removing constraints.

Assessment of Patient Compliance to Artemether –Lumefantrine in Zambia.

Author(s): Pascalina Chanda, Moonga Hawela

Background: One of the Roll Back Malaria (RBM) goals seeks to ensure access to prompt diagnosis and effective treatment. In line with this objective the national Malaria treatment policy in Zambia was revised to replace the failing monotherapies with highly efficacious artemisinin-based combination therapy (ACTs) for the treatment of uncomplicated malaria.

However, effectiveness of the drug does not only depend on its efficacy, but also on factors such as adherence, drug quality, coverage and access. This study is a follow up to the 2004 baseline study which was conducted after the initial deployment of Artemether-Lumefantrine (AL). This will provide the program with information on the trends in compliance over time and form a basis for improving the implementation process and program planning.

Objectives: To Identify factors that influence patient none adherence to treatment protocols in patients with malaria in Zambia

Methods: The study was carried out in RBM districts where AL has been in use. The study was cross-section survey. Observations were done on patients at health facilities with suspected uncomplicated malaria. Outpatient records were used to obtain information age, sex, temperature, weight and residential address. Patients were visited at home after completion of treatment course on day three. Compliance was ascertained through the administration of a semi-structured questionnaire to the patient or caregiver and through physical inspection of empty sachets.

Results: The study showed that the compliance of AL was below the expected 90% (range 45-75%) comparable to the results in 2004. The factors affecting compliance were found to be education status, gender and distance to a health facility. The age was not a significant risk factor for compliance. Males, children less than five years and those living closer to health facilities were less compliant to treatment.

Conclusion: AL being a fixed dose combination has a lot of potential for high compliance to treatment.

Recommendations: Enhance public education campaigns on appropriate use of AL along with intensive monitoring of knowledge, attitudes and practices of both health care providers and health seekers. Include frontline workers in training in best practices for malaria case management.

Evaluation of information Education and Communication(IEC): Knowledge, attitudes and perceptions of malaria control and prevention interventions in Zambian Districts.

Author(s): Pauline K. Wamulume, Pascalina Chanda

Background: The National Malaria Control Centre (NMCC) conducted an evaluation on the impact of IEC materials to determine the level of knowledge, attitude and practices towards malaria interventions on prevention and treatment of both health providers and the community. The study sought to establish the health seeking behaviour and sources of information of the clients. The results intended to feed into the design and development of IEC materials in an effort to facilitate equity of access to cost effective quality assured and cost effective malaria prevention and control interventions close to the households.

Objectives: To identify and assess knowledge, attitudes and practices of service providers and community members that deters people from accessing malaria prevention and control services.

Methods: The study was a cross-sectional evaluation of information in three districts. Data was collected using structured questionnaire for both the health providers and the community.

Results: Knowledge of malaria among service providers and community in survey districts is high. ITNs ranked highest as the known measure of malaria prevention. However, there still remain misconceptions such as cutting grass as a control measure for malaria. With regard to health seeking behaviour, 76% first take patient to the health facility when faced with a case of uncomplicated malaria.

Recommendations: A large scale evaluation be done in consultation with the community and continuous orientations on new malaria drug policy.

In-Vivo drug Efficacy Studies Conducted in Patients under Five Years with Acute Uncomplicated Plasmodium Falciparum Malaria in the Sentinel Sites in Zambia

Author(s): Pascalina Chanda

Abstract:

A 14- day standardised and adapted WHO protocol was used to study the in-vivo drug efficacy of artemether-lumefantrine, sulphadoxine-pyremethamine and SP-artesunate in under five patients with acute uncomplicated plasmodium falciparum year in the sentinel sites of Zambia. The study carried out from during the high malaria transmission season from April 2003 in seven districts. A total of 632 patients were recruited with 183 on AL treatment, 227 on SP artesunate and 222 received sulphadoxine-pyremethamine treatment. It was found that AL had a 14 day cure rate of 98.2% to 100% with a treatment failure rate of 1.8%. SP – Artesunate had efficacy proportions ranging from 91.4-100% with a treatment failure of 4.7% to 8.6%. The two artemisinin based combinations were found to significantly reduce gametocytes carriage while the SP increased gametocyte carriage by the 14th day after treatment. Sulphadoxine-pyremethamine treatment failure rate by 14th day ranged from 7.5% to 32.8%.

TABLE V: TABULATION OF RESEARCH COMMISSIONED OR UNDERTAKEN VARIOUS AGENCIES

| SN | Research/Study/Survey | Commissioner/Funding Agency | Undertaker by | Methodology | Findings | Status | Budget | Research Impact | |
|----|---|-----------------------------|---------------------------------------|---|--|----------------------|--------|--|---|
| | | | | | | | | POLICY | IMPLEMENTATION |
| 1. | First Second Joint Annual Programme Review of National Intervention Strategic Plan – 2004 | WB (ZANARA Project) | NAC, Partners supporting HIV and AIDS | Technical Review and Consultative meetings, Interview of key informants | Gaps in implementation of annual plans and M&E were identified | Completed and in Use | NA | - | Recommendations being implemented by NAC and all implementing agencies, Findings provided input into the annual planning process |
| 2. | Second Joint Annual Programme Review of national Intervention Strategic Plan – 2005 | WB (ZANARA Project) DFID | NAC, Partners supporting HIV and AIDS | Technical Review and Consultative meetings Interview of key informants | Gaps in implementation of annual plans and M&E were identified Priorities set for the next strategic plan | Completed and in Use | NA | - | Recommendations being implemented by NAC and all implementing agencies, Findings provided input into the strategic planning of the national HIV and AIDS Strategic plan 2006-2010 |
| 3. | Demographic Health Survey 2001/2 | UNDP WHO | Central Statistical Office | Data collection Interviews, collection and analysis of blood samples | Health status of population | Completed and in Use | NA | Results have influenced national policy decisions for HIV and AIDS, malaria and control of other communicable diseases | Reference document for management decisions and implementing agencies. |
| 4. | Rapid Socio-cultural Research as a | UNFPA | UNFPA | Rapid Appraisal, Literature | Sketchy knowledge of sexual reproductive health, | Completed and in Use | NA | - | Some recommendations |

| | | | | | | | | | |
|-----|---|---------------------|---|---|--|---|---------|---------------------------------------|--|
| | Methodology for Informing Sexual and Reproductive Health/HIV/AIDS Programming in North-Western Province of Zambia - 2005 | | | Review and Interviews | Youth avoid health institutions; Initiation ceremonies still practiced, but other ethnic groups trying to stop | | | | being implemented by implementing agencies |
| 5. | Sentinel Surveillance - 2004 | WB (ZANARA Project) | Ministry of Health | Interviews and HIV and Syphilis testing | Provided information on the trends of HIV and STI prevalence 1994 to 2004. Overall HIV prevalence has remained relatively unchanged, variations were observed by age group overtime. | Completed and in Use | 30,000 | - | Utilization of Data for program planning and implementation. Used for UNGASS report. In put into the National HIV and AIDS Strategic Plan for 2006-2010. |
| 6. | Research in Traditional and Alternative Remedies - 2005 | WB (ZANARA Project) | National AIDS Council | Clinical Trials | NA | On going | 40,000 | NA | NA |
| 7. | Zambia Demographic Health Survey - 2006 | WB (ZANARA Project) | Ministry of Health and Central Statistical Office | Survey and Syphilis and HIV Testing | NA | On going | 253,000 | NA | NA |
| 8. | Anti Malarial Drug Efficacy Monitoring – 1995 To date | GFATM, WHO, ARCH | NMCC | Survey in 7 districts annually | Chloroquine treatment failure more than 50%. Fansidar treatment failure more than 30%. Coartem efficacy 98-100% | On going each year and dissemination | NA | Revision of anti-malarial drug policy | More effective drug (Coartem) being implemented |
| 9. | Monitoring Compliance to Coartem 2004-2005 | GFATM | NMCC | Survey in 5-7 districts annually | Compliance to Coartem is affected by both health worker and patient characteristics | Completed and in use for previous years - On going annually | NA | - | Improving health worker attitudes and practices |
| 10. | Evaluation of IEC materials - 2004 | GFATM | NMCC | Survey in 3 districts | Knowledge on malaria high, need for behaviour change | Completed and in use | NA | Development of communication | Implementation of communication strategy |

| | | | | | | | | | n strategy |
|-----|---|-------|---------------------------|---|---|--|---------|--|--|
| 11. | Pre- Indoor Residual Spraying (IRS) parasitological and entomological monitoring – 2004-2006 | GFATM | NMCC | Parasitological survey in districts | Survey in IRS districts | On going | NA | NA | NA |
| 12. | Raid assessment of home management of malaria - 2004 | GFATM | NMCC | Assessment (Interviews) of home management in 7 districts | Home management feasible, by Community Health Workers | Completed and in use | NA | - | Training communities on home management through IMCI |
| 13. | Faith Based Organizations implementing HIV/AIDS programs in Zambia - 2005 | NA | CHAZ/GLOBAL FUND Trop Med | Cross sectional Survey | NA | Completed and in use | NA | - | Information being used for advocacy for more funding to FBOs. |
| 14. | Evaluation of Institutional Capacity Building of Health Economies in Zambia | SIDA | SIDA, UNZA, IHE (Sweden) | Seminars, Interviews, Study visits | Dire need exists to capacity build Health economics | Completed and in Use | | - | Results used to develop systems and build capacity |
| 15. | Costing the Basic Health Care Package - 2001 | SIDA | UNZA – DoE /MoH | Field work and data analysis | Basic Health Care Package cost estimated. | Completed but not in Use | 40,000 | NA | NA |
| 16. | Health Care Financing - 2004 | SIDA | UNZA – DoE /MoH | Field work and data analysis | Inequality of user fees Health service motivation | Completed and in Use | 140,000 | User fees removed | New provider incentives thought of and included in the strategic plan for human resources. |
| 17. | Paying the providers - 2004 | SIDA | UNZA – DoE /MoH | Field work and data analysis | NA | On going | 20,000 | NA | NA |
| 18. | National Health Accounts up to 2004 | SIDA | UNZA – DoE /MoH | Field work and data analysis | Main financiers of health care determined | Completed and in Use | 40,000 | Income and expenditure formats developed and adopted | Income and expenditure formats adopted and in Use |
| 19. | HIV and AIDS and health systems - 2005 | SIDA | UNZA – DoE /MoH | Field work and data analysis | HIV and AIDS creates new institutional structure | Completed and in Use and On going (has | 28,000 | - | - |

| | | | | | | | | | |
|-----|--|------|--|---|--|--|--------------------------|----|--|
| 20. | Private sector Participation Study - 2001 | SIDA | UNZA – DoE | Field work and data analysis | NA | many phases) Completed and in Use and On going (has two phases) | 14,000 | - | - |
| 21. | HIV (ART) program sustainability - 2005 | SIDA | UNZA – DoE | Field work and data analysis | NA | On going | 18,000 | NA | NA |
| 22. | Cost effectiveness of Malaria interventions - 2005 | SIDA | UNZA – DoE | Field work and data analysis | NA | On going | 18,000 | NA | NA |
| 23. | Disease burden and health care - 2004 | SIDA | UNZA – DoE | Field work and data analysis | Health Care availability affects disease patterns | Completed not in Use | NA | - | - |
| 24. | Disentangling HIV and AIDS Stigma in Ethiopia, Tanzania and Zambia - 2001 | DFID | ZAMBART | Qualitative data collection-participatory | -Most people know how HIV is transmitted -Most people do have good intention when practising discrimination | Completed and in Use | 120,000 | - | Being put into practice. |
| 25. | Action Research Unit - 2002 | DFID | ZAMBART/DHMTs Consultant Virginia Bond | Health Systems research | Operational research is important in TB control | Completed and in Use | 25,000 pa British pounds | - | Influencing implementation |
| 26. | Integration of PROTEST and PMTCT - 2001 | DFID | Consultant Helen Ayles | interviews | Integration of PROTEST and PMTCT done | Completed and in Use | \$176, 840 | - | PROTEST integrated in routine services |
| 27. | Timing and its significance in diagnosis and treatment of TB - 2003 | DFID | Consultant Amos Nota | Cohort Study | NA | Not disseminated | NA | NA | NA |
| 28. | Are more dangerous strain of TB circulating in Southern Africa - 2003 | DFID | Consultant Grace Mbulo | Molecular epidemiology | NA | On going | NA | NA | NA |
| 29. | Zambia and South Africa AIDS reduction study - 2004 | DFID | Consultant Helen Ayles | Community randomised trial | NA | On going | NA | NA | NA |
| 30. | Sexual Behaviour Study - 2004 | DFID | Consultant Nomsa Sibande | Case Control Study | NA | Not Disseminated | NA | NA | NA |
| 31. | Zambia Health Facility Census 2005 | JICA | JICA and DHMTs | Field work and consultative meetings | Status of health facilities in Zambia Health system known | On going | 1,000,000 | - | - |

| | | | | | | | | | |
|-----|--|--------------------------|--------------------------|---|--|--------------------------|--------|----|--|
| 32. | Operational Research on Integration of community-Based Directly Observed Therapy (DOTS) for TB and ART - 2004 | JICA | UTH Virology laboratory | Interviews | NA | On going | 50,000 | NA | NA |
| 33. | Care Moyo Wa Bana Project Survey-Measuring care giver behaviour change in relation to health issues 2003 | CIDA | Care International (Z) | Survey-Collection of quantitative and qualitative data | Reduced infant & child morbidity due to diarrhoea malaria and pneumonia Improved care taker's knowledge children's diseases and on HIV/AIDS | Completed and in Use | NA | - | Being implemented in many health centres. Measuring care giver behaviour change in relation to health issues |
| 34. | Moyo Wa Bana IMCI: Improving children's health through improving human capital - 2003 | CIDA | Care International (Z) | Survey-Collection of primary data and review of secondary information | - Malaria, diarrhoea and pneumonia still major killer diseases -Better Caretakers knowledge -Shortage of qualified staff in most health facilities | Completed and in Use | NA | - | Recommendations being implemented. Improving children's health through improving human capital |
| 35. | Evaluation of case management- 2004 | USAID/ Boston University | NMCC/ Boston University | Interviews in 4 districts | Practices in treating fever not consistent with guidelines | Completed and in Use | NA | - | - |
| 36. | Cost effectiveness evaluation of home management 2005 | Novartis | NMCC | Economic evaluation in 6 districts | Coartem is more cost effective than Fansidar | Completed but not in use | NA | - | - |
| 37. | Pregnancy Registry - 2005 | NA | NMCC/TDRC | Review of records in one district | NA | On going | NA | NA | NA |
| 38. | Coverage of Church Health Services in Zambia - 2005 | KIT | CHAZ | Cross Sectional Survey | NA | On going | NA | NA | NA |
| 39. | Coping with the impact of HIV/AIDS on Health Workers in Zambia: A Pilot study in two districts - 2005 | NIH/NIAID | CHAZ/KIT | Cross-sectional Survey | NA | Not Disseminated | NA | NA | NA |
| 40. | Expenditure Ceilings, Human Resources and Health: The Case for Zambia - 2005 | WEMOS/COR DAID | CHAZ/WEMOS/CORDAID /CSPR | Cross sectional survey | NA | Not disseminated | NA | NA | NA |

| | | | | | | | | | |
|-----|---|------------------------|---|--|---|--------------------------|--------------|---|---|
| 41. | Linking Health to Development – An Option for Sustaining Gains from the RBM Initiative for People of Chama District in Zambia - 2002 | WHO | CHESSORE | Fieldwork – Primary and Secondary data | Benefits from GFTAM can be coupled with poverty reduction | Completed and in Use | US\$11,000 | - | Linking Health to Development – An Option for Sustaining Gains from the RBM Initiative for People of Chama District in Zambia |
| 42. | The benchmarks of fairness for health reform in Zambia- 2003 | WHO | CHESSORE with Prof N. Daniels – Harvard (USA) | Fieldwork + Workshop | Key issues of concern in terms of equity and social justice on ART identified and justified | Completed but not in Use | US\$ 15,000 | - | The benchmarks of fairness for health reform in Zambia |
| 43. | Impact of HIV/AIDS on human resources for health In ZAMBIA - 2005 | WHO | CHESSORE | Fieldwork | The impact of HIV/AIDS on the health workforce ascertained from health worker perspective | On going | US\$20,000 | NA | Impact of HIV/AIDS on human resources for health In ZAMBIA |
| 44. | The Equity Gauge of Zambia (EGZ) – Phase 1 - 2001 | Rockefeller Foundation | CHESSORE | Workshops + Fieldwork | Stakeholder participation on issues of concern at the interface between the health system and community enhanced, advocated and magnitude determined. | Completed and in use | US\$ 409,000 | - | The Equity Gauge of Zambia (EGZ) – Phase 1 |
| 45. | The Equity Gauge of Zambia (EGZ) – Phase 2 - 2006 | NA | CHESSORE | Workshops + Fieldwork | Equity in health service provision and health budget allocation to support policies determined /followed up. | Completed and in use | - | Resource allocation formula being reworked | The Equity Gauge of Zambia (EGZ) – Phase 2 |
| 46. | A policy process analysis of decision making for priority setting from the bottom-up approach priority setting for PHC | IDRC – EQUINET | CHESSORE | Fieldwork | Stakeholder participation in health frustrated by an over reliance on use of power, with the more powerful partners dominating decision | Completed and in use | US\$10,500 | Local policy guidelines in the Equity gauge districts being | A policy process analysis of decision making for priority setting from the bottom-up |

| | | | | | | | | |
|-----|---|------------------------|----------|-----------------------|--|----------------------|---|--|
| | in Zambia - 2004 | | | making | | | strengthened to support community participation | approach priority setting for PHC in Zambia |
| 47. | The acceptability of Olyset long lasting nets in Zambia (Users views on Olyset net) - 204 | WHO | CHESSORE | Fieldwork | Factors contributing to the acceptability of long lasting ITNs (LLN) in Zambia determined | Completed and in use | US\$8,000 | LLNs use in Zambia malaria control programme approved |
| 48. | Proposal to undertake Advocacy on the RBM initiative in Zambia as a global public private partnership in health - 2004 | WEMOS | CHESSORE | Fieldwork | Popular participation in the malaria component of GFATM programmes assessed. | Completed and in use | US\$13,000 | Advocacy with the GFATM board through Northern NGOs |
| 49. | An initiative to develop a regional network for integrated diseases surveillance network across SADC Countries 2002 | Rockefeller Foundation | CHESSORE | Fieldwork | Language, Human resource crisis, Budgetary constraints, Poor/ lack of policy implementation and lack of policies contributed to poor coordination between SADC countries for disease outbreaks across borders determined | On going | US\$140,000 | Discussion paper being written for onward advocacy with SADC ministers of health |
| 50. | Monitoring equity and health systems issues in art programmes in Southern Africa - 2006 | WHO | CHESSORE | Fieldwork, Desk study | An annual equity picture and health system strengthening effects in the wake of ART scaling up being compiled / determined | On going | US\$74,000 | - |
| 51. | Decision-Making and Priority Setting for | WHO | CHESSORE | Fieldwork | Overwhelming donor funding, donor | Completed and in | US\$28,000 | Bilharzia policy/focus |
| | | | | | | | | Decision-Making and Priority |

| | | | | | | | | | |
|-----|--|--|---|---|---|------------------------------------|-------------|------------------------|---|
| | Schistosomiasis Control in Zambia: The Case of Chama District. - 2003 | | | | conditionalities, centrally determined priorities, and limited decision space constrained DHMT responses to fight highly prevalent neglected tropical diseases in Zambia. | use | | strengthened in Zambia | Setting for Schistosomiasis Control in Zambia: The Case of Chama District. |
| 52. | Governance, participatory mechanisms and structures in Zambia's health system: an assessment of the impact of Health Centre Committees (HCCs) on equity in health and health care- | CHESSORE funded by IDRC – EQUINET (13) | CHESSORE | Fieldwork | Community participation in health is desirable and possible, but action was needed to help overcome constraining factors. | Completed and in use | US\$ 20,000 | CBoH now dissolved | Governance, participatory mechanisms and structures in Zambia's health system: an assessment of the impact of Health Centre Committees (HCCs) on equity in health and health care |
| 53. | RAPIDS Impact Assessment Baseline Survey Report - 2004 | Africare – RAPIDS | Population Council Horizons Program & RuralNet Associates | 6 districts – surveyed household heads, children (10-14 yrs), and youth (15-18 yrs) for 1500 households | - Poor living conditions - Limited differences in household living conditions among households affected by HIV and AIDS - similar Service coverage all households, affected by HIV and AIDS or not - RAPIDS known in community, services in demand - Confusion between OVC and HBC caregivers | Completed, final report in process | 341, 648 | - | - |
| 54. | Livelihood Market Assessment and Youth | Africare – RAPIDS | Africare Zambia | Lusaka and Chongwe | - Availability of locally produced materials, | Completed and in | NA | - | Livelihood Market |

Situational Analysis

through
Private
Consultant
(Mr. Belmar S.
Bayombong)

districts –
survey
questionnaires
conducted and
focused group
discussions on
youth
livelihood and
situation

products, and services
use
- Labor market analysis
- Youth/Household
situation
- Existing youth programs
- Skills training
- Microfinance and
banking resources

Assessment and
Youth
Situational
Analysis

DISCUSSION

Donors through their support to Zambia are involved in influencing governance and policy processes within the government. This support could influence what priority health research issues that can be put on the government's agenda.

From the one on one interview, it was clear that, although donors and NGOs recognise the need to use evidence, there are no established formal links to inform policy and program implementation including ensuring that the primary evidence is easily accessible within the public domain. Resources are used for dissemination within a workshop setting and distribution of information mainly to relevant targeted stakeholders

During this study it was easier to obtain information and reports on a particular research/survey from the institution or researcher that undertook the research than from most donor agencies supporting a particular research.

The fact that only 16.7% of research results reported were used for policy and 38.9% for implementation, point to the need for more active participation and collaboration among the policy makers, donors, managers and researchers in prioritizing, planning and implementation as well as increased advocacy for usable information from researches including wider dissemination of results.

CONCLUSIONS

While it is true that some researches commissioned or undertaken by International donor agencies and NGOs, are to some extent being used in program implementation, there still remains a gap between research and policy development. *What is needed is moving the agenda forward to accelerate the use of evidence from operational research to policy development and program implementation in Zambia.* In making this conclusion, an understanding is required on how decisions on health research outcomes are made, disseminated and utilized throughout the health care delivery system and among relevant stakeholders.

From these results one would note that operational research focused on Public Health and Health System Development tend to influence policy development and program implementation in Zambia.

It is hoped this paper has contributed to the discussions and experiences on how health research is undertaken, commissioned and how results are being utilized by government and all stakeholders in health in Zambia.

RECOMMENDATIONS:

In making the following recommendations, consideration of the limitation of this study on literature review on the type of researches that have been conducted in Zambia has been taken into account.

5. **Development of Health Research Capacity in Zambia:** Capacity in health sector refers to the ability to carry out stated objectives i.e the expertise and resources at individual and organizational and system levels for the production and application of new knowledge to health problems. At individual and organizational levels capacity include the skills and competences, leadership, partnerships, development of appropriate workforce and institutional frameworks and the ability to mobilize and allocate resources. *In order to build this capacity for Zambia, a study to determine capacities required to act on health research evidence in informing policy and program implementation need to be conducted. This will include determination of the available capacities on Health Research in Zambia and factors influencing utilization of health research outcomes within the context of the role of health research in national economic development.*
6. **Establish an Institutional Framework for Health Research:** A lot of health research is being conducted by various organizations in Zambia, the question is how to link all these activities to get a synergistic effect. Organizational leadership is critical to translating evidence into actions and practice. In order to maximize assistance to health research, there is need to establish an institutional mechanism (supported by government and donors) that will have the capacity to provide leadership in health research in Zambia, translate evidence into practice by providing usable guidance to policy makers, managers, professionals and consumers of health research outcomes. *To do this, a systematic study of the current institutional setup for health research in Zambia to identify gaps needs to be done.*
7. Most research is funded by the donors, the **Government of Zambia to include a Budget line in its budgeting process for health research and staff time** to conduct and promote utilization of health research outcomes in Zambia. In addition, to foster collaboration and coordination, donors to support health research within the context of the health sector SWAP.

8. Reduce the gap between evidence and implementation by;
 - Ensuring that health research development is a priority within the National Health Strategic Plan and National Development Plan. Integrating evidence into routine health care practice within health institutions.
 - Increasing the accessibility to evidence on health research through wide dissemination to all stakeholders and building capacity in communicating health research for policy development. Involvement of politicians and key respected and influential people in the design of research and dissemination of research results
 - Building greater links between the policy makers, researchers and the implementing agencies

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APPENDICES:

LIST OF AGENCIES/INTSITUTIONS CONTACTED

| SN | ORGANIZATION | CONTACT | PHONE | E-MAIL |
|-----|----------------|---------------------|-----------|--|
| 1. | CARE | Mrs. Mwendafilumba | 221687/22 | |
| 2. | CBOH | Mr. B. Chita | | |
| 3. | CHAZ | Dr. Biemba | 096764621 | |
| 4. | CHESSORE | Dr. T. J. Ngulube | 095914844 | |
| 5. | CIDA | Elison | | |
| 6. | COM. MEDICINE | Dr. Likwa Ndonyo | 09836764 | |
| 7. | CSO | Mr. M. Banda | 253286 | |
| 8. | DFID | J. Miller | 251164 | |
| 9. | EU | Mr. E. Rossetti | | Emilio.rossetti@cec.eu.int |
| 10. | HSSP | Dr. Macwang'i | 097826823 | |
| 11. | JHPIEGO | Dr. C. Mazimba | 256255 | Cmazimba.misp@jhpiego |
| 12. | JICA | Mr. S Sasaki | 251474 | |
| 13. | JICA | Mrs. Sichone | 254501 | |
| 14. | JICA | Mrs. P. Likwasi | 2555o1 | |
| 15. | LDHMT | Dr. Sinkala | 097847288 | |
| 16. | MOH | Mr. C. Simoonga | 253053 | simoongachris@yahoo.com |
| 17. | MOH | Mr. D. Chimfwembe | 097748584 | dchimfwembe@moh.gov.zm |
| 18. | MOH | Mr. V. Mukonka | 097844754 | |
| 19. | NMCC | Pascalina Chanda | | malaria@nmcc.org.zm |
| 20. | NMCC | Dr. N. Sipilanyambe | 097888694 | malaria@nmcc.org.zn |
| 21. | RAPIDS | Mrs. K. M-Musimwa | 265845 | kmushimwa@africare.org.zm |
| 22. | SFH | Mr. N. Shiliya | 292443 | Nicholas@sfh.org.zm |
| 23. | SHARE | Dr. K.Ofosu-Barko | 255616 | Kenneth.ofusu-barko@share.org.zm |
| 24. | SIDA | P. Eriksson | 251711 | par.eriksson@sida.se |
| 25. | UNDP | Delia | 250800 | |
| 26. | UNFPA | Dr. Malumo | 250800 | malumo@unfpa.org |
| 27. | UNICEF | Dr. T. Shiferaw | 254696 | tshiferaw@unicef.org |
| 28. | UNZA (DoE) | Mr. C. Cheelo | 290475 | ccheelo@hss.unza.zm |
| 29. | USAID | C. Lwamba | 254303/6 | clwamba@usaid.gov |
| 30. | WB | Dr. M. R. Sunkutu | 252811 | rsunkutu@worldbank.org |
| 31. | WHO | Dr. Masaninga | 255322 | |
| 32. | ZAMBART | Dr. M.F. C. Banda | | mfcbanda@zamstat.gov.zm |
| 33. | ZANARA (MoFNP) | Mrs. Olive Chiboola | 227029/49 | zanara@zamtel.zm |

DATA COLLECTION TOOL

Kindly try as much as possible to respond to each item.

| QUESTIONNAIRE ON OPERATIONAL HEALTH RESEARCH CONDUCTED BY INTERNATIONAL DONORS AND NGOs IN ZAMBIA PAST FIVE (5) YRS | | | | | | | | | |
|---|--|---|--------------------|---|-------------------------------------|--|--|----|--|
| 1 | International Agency Name | 2 | Duration in Zambia | 3 | Organization's Mandate | 4 | How many Operational Research Projects undertaken/commissioned past 5 years? | | Completed On/...../2006 By : |
| 5 | | | | | 5 | What is your Research budget like annually | | 10 | At what stage is the study project named in (6) now? Is it (a) completed and in USE (b) Completed,, but not in USE |
| 6 | Name of Operational Health Research project Commissioned (Add attachment where necessary) | | | 7 | When was it Commissioned? (Year) | 8 | Who did undertake this research? | 9 | How was it undertaken? (c) Not disseminated (d) On Going Please Indicate-a, b, c, or d below. |
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
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| 11 | What were the Main Research Findings of 1-10 above | 12 | What were the FUNDING levels? | 13 | If Research results used, what Impact did/has the Findings had at various Levels? | | 14 Please do supply copy (copies) of documents-In what form? Tick choice | | |
|----|--|----|-------------------------------|----|---|----------------|--|------------|----------|
| | | | | | Policy | Implementation | Hard | Electronic | Diskette |
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NOTE: Please take note that the information supplied will be treated with all the confidentiality required and will not be published without your knowledge.