Zambia
Child Health Week

Lessons learnt in improving children’s lives

November 2017

unicef

Leave no one behind

Child Health Week provides a high-impact package of integrated services delivered at the community level to children under five

Introduction

To reach the most number of children possible, regular events to deliver an integrated package of key nutrition and health interventions to children and mothers, commonly referred to as Child Health Days (CHDs), were introduced in the Eastern and Southern Africa Region (ESAR) over two decades ago. Conducted twice per year, these activities can last one day, a week or a month. Interventions during CHDs vary by country, but core activities include vitamin A supplementation (VAS), deworming, immunisation, and social mobilisation and communication activities to promote immunisation and the uptake of new vaccines. Many countries also include the promotion of key health and nutrition practices, screening for malnutrition, hand washing and sanitation.

This summary brochure documents key components of the Child Health Week (CHWk) programme in Zambia. Using existing quantitative data and newly gathered primary qualitative data, the documentation exercise addressed seven key themes: the CHWk programme including core interventions and coverage; decentralisation and ownership; coordination, supervision and training; supply and provision of services; community experiences; issues of equity; and sustainability.

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Zambia

In order to reach the most children possible with key interventions, Zambia began to implement Child Health Week in 1999, building on the Expanded Programme on Immunisation (EPI), which took a vertical approach to health service delivery in the form of campaign-style events.

CHWks are held biannually in June and December. The first campaigns included VAS and growth monitoring and promotion for children aged between six and 59 months. In 2003, deworming with Mebendazole was added, then intermittent treatment of insecticide-treated mosquito bed-nets and their promotion in 2004.

The Ministry of Health removed mop-up immunisation from the package of services in 2013, but reintroduced it in 2015 as CHWks were recognised as an effective means to catch children who had missed opportunities for vaccination in the routine system.

National-, provincial- and district-level stakeholders confirmed that CHWks differed in design between regions. Given the decentralized nature of the Zambia health system, districts have relatively high input into planning the CHWk service package and flexibility to adapt the package to the needs of their communities.

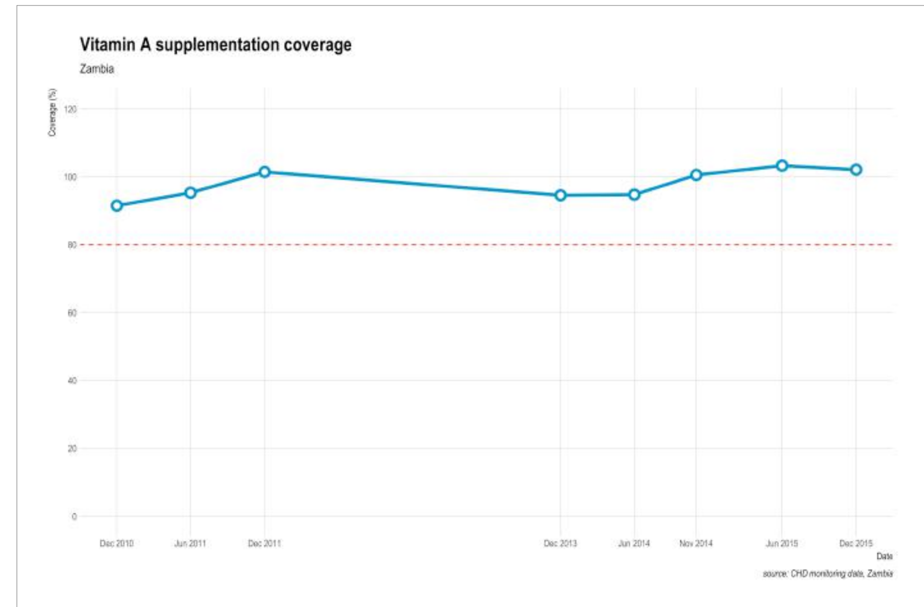
In 2016, the core package of services offered during CHWks included VAS, deworming and 'catch-up' immunisation, with scope for districts to incorporate additional interventions according to local priorities tailored to the needs of local communities.

CHWk overview

Interventions

Vitamin A supplementation

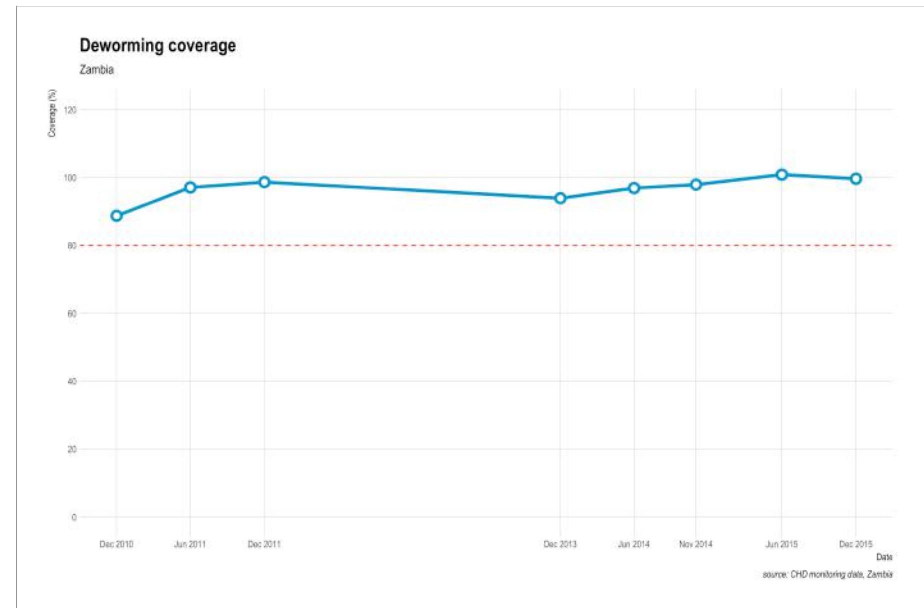
Vitamin A supplementation (VAS) was considered by many stakeholders to be the driving force of CHWk, and demand for it was high given that routine provision for VAS was weak. CHWk monitoring data, calculated from administration data collected at the facility level during each round of CHWk indicated that national VAS coverage rates have remained consistently high over recent years, and were above 90% for all CHWks implemented between December 2010 and December 2015 (see graph 1). At the provincial level, a similar pattern was observed. In the two CHWks in 2015, average coverage was 106% (coverage data is reported to be higher than 100% because of denominator issues).



Graph 1: According to the monitoring data, national VAS coverage rates were above 90% for CHWks implemented between December 2010 and December 2015. (Note: no data was reported for 2012 and June 2013 rounds, hence the gaps in the plot above).

Deworming

Since its introduction into CHWk, the coverage of deworming using Mebendazole has been consistently high, and is perceived by caregivers to be a positive intervention that encourages their attendance at CHWk. According to the monitoring data, all CHKs between 2010 and 2015 attained over 90% coverage nationally, with a mean of 98% (see graph 2). In the two CHWs in 2015, the national deworming coverage rate was 104% in June, and 101% in December, but only minor provincial variations in coverage were evident.



Graph 2: According to the monitoring data, CHWks implemented between December 2010 and December 2015 attained over 90% coverage nationally, with a mean of 98%. ((Note: no data was reported for 2012 and June 2013 rounds, hence the gaps in the plot above).

Interventions

Mop-up immunisation

Immunisation is provided as a key component of routine service delivery. In 2013, the Ministry of Health removed vaccination from the CHWk package, but reintroduced it in 2016 to 'mop-up' missed opportunities. Despite the high rate of uptake of immunisations through the routine system, CHWk provides a safety net to ensure no children miss vaccinations and national-level stakeholders perceived its reintegration to be wholly positive.

Social mobilisation

Social mobilisation has been a core component of CHWk since its inception, used to raise awareness about key interventions and mobilise communities to seek services. In remote and hard-to-reach areas mobilisation efforts remain critical and multiple strategies are employed including interpersonal communication, the distribution of information education communication materials, public announcements and radio and television broadcasts at national and local levels. Information about the campaign (its dates, inventions offered and resulting health benefits) is disseminated by community health workers who go door-to-door in their communities to convey core messages, but is also disseminated at facilities and during outreach activities. Community health workers are the primary drivers of social mobilisation because they are 'close to' and trusted by the communities they serve, but social mobilisation activities are most successful when community and leaders are also engaged and actively encourage caregivers to attend CHWk.

'Many of us don't usually come out for routine services, but when they come to the community during CHWk, we come and they give us the medicines very quickly so the waiting time is less and the health workers and community volunteers help us very well. I found out about they CHWk in my village. It is the headman who announces it. This is useful to encourage parents to come'.

Caregiver, Kafunka, Katete

Decentralisation and ownership

The health system in Zambia is decentralised with a strong infrastructure that provides high quality routine services through primary health care facilities. The success of CHWk is largely dependent on the strength of the district health system. The decentralised system facilitates ownership of CHWk at the district level, encourages greater planning and an implementation of interventions, and better integration with routine health services as funding is allocated at the district level as part of the broader health systems plan. Government funds are allocated directly to districts according to their microplans that tailor CHWk activities according to local priorities. District-level stakeholders highlighted sub-national budgeting as one of the key successes of decentralisation.

In turn, CHWks strengthen the primary healthcare system, and facilitate the supportive supervision of frontline health workers during campaign-style interventions.

Increased ownership at the community level is also evident and health facilities have assumed a higher degree of involvement in planning CHWks to meet the specific needs of communities in their catchment areas. Governing committees at each facility ensure that influential members of the community are involved and engaged in planning and problem-solving for CHWks. Such community engagement has made a positive contribution to the programme's sustainability and reinforced local capacity building.

'I see partner support as complimentary to what the government provides. If the fiscal space were large enough, the government would meet all costs, but there are limitations. So when partners come in, they compliment government efforts and therefore district managers are able to assign and move resources accordingly to fill gaps. I see donor support as complimentary, but not as the source of funding for the CHWk activities'.

National-level stakeholder

Coordination, supervision and training

The National Food and Nutrition Commission was the primary coordinating body for CHWks between 2000 and 2010, and was instrumental in establishing the Scaling Up Nutrition movement in the country, encouraging the integration of nutrition as a cross-cutting issue. In 2011, when CHWk activities were well established and achieving consistently high coverage rates, responsibility for CHWk was assumed by the Ministry of Health. The appointment of a CHWk focal point and technical working group has contributed to improved coordination and stronger commitment to nutrition at the national level.

Monitoring and supervision during CHWks are organised through a cascade approach, from the national to the provincial and district level. This vertical structure supports the upward flow of data from facilities to higher levels.

District Medical Officers are responsible for planning and budgeting training for CHWks. Health workers and community health volunteers receive training and orientation on CHWk implementation, interventions and social mobilisation, although many health workers requested further training and refresher courses.

Data on VAS and deworming are collected by community health workers during CHWk activities. From the provincial level, data are channeled upwards to be centrally compiled by monitoring and data specialists at the Ministry of Health. Aggregated data are then shared with supporting partners, including UNICEF.

'A lot of coordination is done by the districts and the provinces themselves. At the national level, we do the coordination, policy and strategic planning to support the districts. So even when you plan for CHWk activities at the national level, we also influence and support the planning at the district and provincial levels.

There are teams from the central level that go to various districts to monitor and among the assignments for the team members are activities at the community level. One thing is to conduct an exit interview. Then when we come back we are able to analyse and get a sense, here at the national level, about what the community members are really saying about the services'.

National-level stakeholder

Supply and provision of services

The government is responsible for the clearance of supplies through customs and their management from the central level, ensuring stocks reach every district for roll-out to the various service delivery points. UNICEF supports the government to procure both vitamin A and Mebendazole for CHWk, and Nutrition International and World Vision also support VAC procurement.

Human resource shortages persist across the Zambian primary health care system, and lower-level facilities only employ one or two professional health workers. Because of this, many participants emphasised the challenge that health facilities faced in providing routine services, immunisations and outreach during CHWks.

Stakeholders at all levels emphasised the role of community health volunteers and the commitment they invested to ensure communities accessed CHWks. Community health volunteers themselves suggested that they worked for the campaign because of the positive impact they had seen it brought their communities, but noted that the lack of resources made available to them could have a negative impact on their motivation and had led to attrition of volunteers.

‘We are volunteers and we are happy serving. Our mandate is to serve the community. We want to be volunteers and we do not actually ask for a lot in return, just some small appreciation’.

Community Health Worker, Luangwa

Community perceptions

The social norm is for mothers to be responsible for their child's health. A mother is more likely to identify symptoms in a child, and if care is needed, is responsible for presenting the child at a health facility. In terms of preventative care, mothers are also responsible for attending routine services for vaccination and presenting at CHWks. It was suggested that women were increasingly gaining power and agency to make care-seeking decisions for their families, although men remained responsible for the provision of finances and transport to facilitate attendance.

Although a number of rumours about CHWk services and vaccinations were reported, these varied across different tribal and religious groups. Some participants suggested members of certain churches were prohibited from accessing health services although it was noted that members of these congregations often came to the CHWk '*in secret*'. Community-level stakeholders emphasised that together, the provision of effective treatment and education by Community Health Volunteers (CHVs) helped to dispel rumours and build community trust in the interventions. National-level stakeholders agreed that CHWk had become 'institutionalised' at the community level, and caregivers had '*become so used to this service*' that through effective and targeted messaging, rumours and misconceptions were minimal.

'People want to come. They know the importance of the CHWk, it is just about finding a strategy for engaging them and we have done this with the CHVs'.

Community Health Worker, Luangwa

‘CHWk is a week for children up to five years old to get vitamin A, deworming and injections. These are important because they help children to survive. During the CHWk, you are taught how to take care of the child, what food to give them, and about the vaccines that children are supposed to have.

I am a teacher. The CHVs come to our schools to do social mobilisation. It is a good programme. There are many temporary health posts where you can get the services, so the people don’t have to go far. The health clinic is a long distance from here, so when they come close with the services, this helps the people. It saves time and energy. We can just walk to the health post.

When they include vaccines and deworming medicine in the CHWk, it encourages many parents to come and bring their children. The CHWk will cater for many people. They announce it on television and radio, but where I am from, it’s a village setting, so the headman announces that there will be a CHWk and that these activities are going on. They announce it so that everybody can hear’.

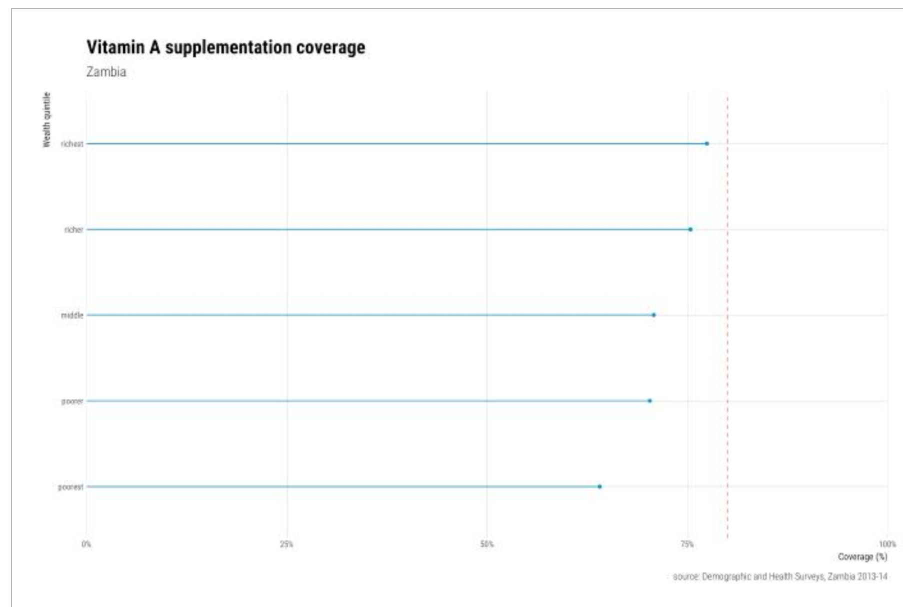
Caregiver attending CHWk, December 2016

Equity

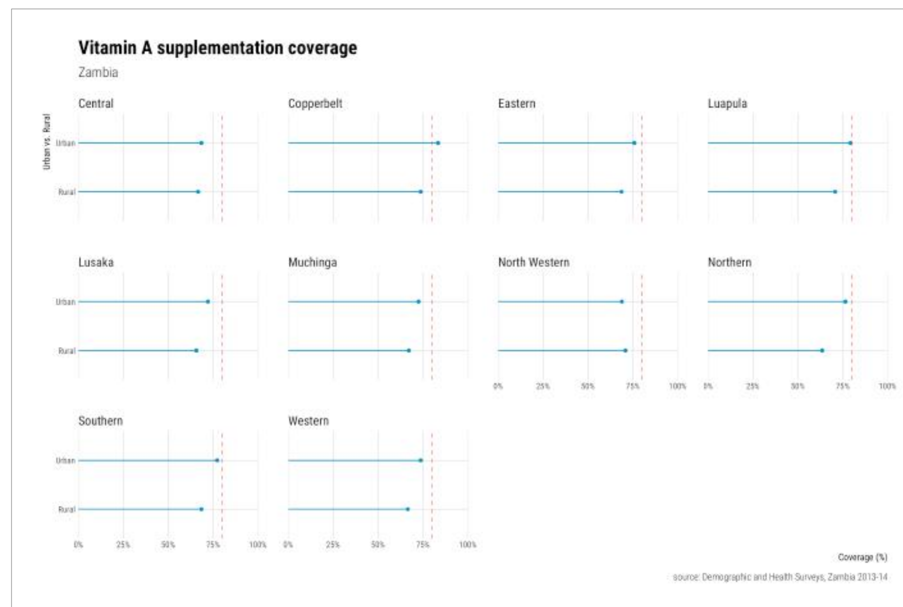
In order to explore issues of equitable delivery of and access to services, an analysis of wealth quintile at the household level was undertaken using the DHS dataset (2013-2014) that includes five categories from poorest to richest. Nationally, the overall pattern was one in there was highest coverage in the richest two quintiles, and lowest coverage in the poorest quintile, although the magnitude of difference was only moderate, from 77% in the richest, to 64% in the poorest quintile (see graph 3). In the qualitative data, poverty was not raised as a determinant of coverage, rather stakeholders referred to caregivers' general lack of motivation as influencing their access to services.

In the DHS data, there was no clear observable pattern in VAS coverage between urban and rural settings (see graph 4), although the mean coverage among urban households was a little higher at 75% compared to rural households at 68%. In the qualitative data, however, stakeholders suggested that administration of CHWks was most challenging in rural areas due to geographic and logistical challenges.

Across all stakeholder groups, no association was made between a child's gender and access to CHNM. This finding was triangulated with the quantitative analysis of coverage data from the DHS where no difference between male and female uptake of VAS services was observed.



Graph 3: According to the DHS data (2013-2014), nationally there was highest VAS coverage amongst the richest two quintiles, slightly lower among the middle and poorer quintiles, and lowest among the poorest quintile. However, the magnitude of difference was only moderate, from 77% coverage in the riches, to 64% coverage in the poorest quintile.



Graph 4: According to the DHS data (2013-2014), there was no clear observable pattern in VAS coverage between urban and rural settings, although the mean coverage among urban households was somewhat higher at 75% compared to 68% for rural households.

Sustainability

National-level stakeholders noted that campaign-style interventions can effectively target populations in need, and provide care to those who did not engage in routine services. CHWk is also regarded as a valuable mechanism to provide care to children who had missed opportunities as part of routine services, and the campaign could act as an effective safety net for the health system.

It was suggested that increased government ownership and financial commitment to CHWks would eventually lead to a shift from campaign interventions to routine delivery. It was well recognised, however, that this shift would have to be implemented slowly and in parallel to broader health system strengthening. The transition of immunisation from an intervention provided during dedicated campaigns to one integrated into routine service delivery was seen by some stakeholders as good practice, but whilst lessons could be learned from this experience, it was widely acknowledged that a campaign-style approach would have to be maintained for other interventions (VAS and deworming) in the short- to medium-term.

The government has demonstrated commitment to the CHWk programme by increasing their levels of ownership and introducing mechanisms for financing and decentralising responsibilities to the district level. Despite this, it was highlighted that the longevity of CHWks remained reliant on long-standing support from external organisations, and this would need to continue until the routine health system was adequately resourced.

Conclusion

The Child Health Day programme has been successfully implemented in Zambia for over eighteen years. In 2016, several positive achievements were documented: strong political ownership; increased fiscal control, the reintegration of immunisation to 'mop-up' children who had missed routine vaccinations; and the consistently high coverage rates for VAS and deworming. Several key components have contributed to the success of CHWk in Zambia:

Decentralised health system. The development of district-level microplans, and the increased role of the district management office in planning and budgeting have enabled interventions to be better tailored to the immediate context and receptive to the needs of the target population. This has fostered a greater sense of ownership and accountability at sub-national levels. To sustain these advances, the government should be encouraged to expand human resource capacity, particularly in relation to planning and budgeting, and a greater level of accountability should be built into the programme. External partners should support the government to increase their commitment and to dedicate sufficient resources to CHWks.

Effective social mobilisation. In Zambia, social mobilisation and community engagement have been key to raising awareness of CHWks and encouraging utilisation of services offered. Multiple methods of social mobilisation are used, but actively engaging community leaders in social mobilisation is seen to be highly beneficial as they are able to foster trust, help dispel negative rumours, and encourage attendance at CHWks. It is critical that targeted social mobilisation be continued and adequately resourced to encourage positive uptake of CHWk services.

Equity-focused approach. The equity-focused approach to CHWk that is implemented in Zambia seeks to ensure that the services reach the most vulnerable children in the hardest-to-reach areas. Through their microplans, the district management office can plan interventions and outreach that bring services closer to the community and target children who are most in need.

	Lessons learnt and good practices
CHWk programme	• The key interventions offered during CHWk are focused and mutually supportive. The reintegration of immunisation into the campaign in 2015 was positive as it provided an important opportunity to 'mop-up' children who otherwise missed routine vaccinations. • Social mobilisation and community engagement are key in raising awareness of CHWks and encouraging utilisation of services offered. Multiple methods are used and hard-to-reach communities specifically targeted. Engaging community headmen, channelling messages through religious institutions and schools, and engaging community health volunteers in social mobilisation activities are seen to be particularly beneficial. Radio was also reported to be an effective mode of communication.
Decentralisation and ownership	• Decentralisation in Zambia is a strength and has contributed to a high degree of ownership of CHWks at both central and local government levels. The development of district microplans has helped to develop a positive sense of responsibility for the programme. The increased role of district medcial offices in CHWks has facilitated greater district-level planning and enabled interventions to be better tailored to the local context and receptive to the needs of the target population.
Coordination, supervision and training	• There is positive collaboration between the Ministry of Health and the National Food and Nutrition Commission. The National Food and Nutrition Commission supported the development of the CHWks programme and has successfully raised the profile of nutrition across government. The presence of a CHWk focal point and technical committee has improved coordination for and commitment to the biannual campaign. • Central government review and feedback on provincial- and district-level reporting has increased accountability and ownership at sub-national levels and has generated positive motivation. The cascading monitoring and supervision mechanisms are effective and the involvement of national-level stakeholders in local-level monitoring visits and exit surveys provides them with a greater understanding of community perspectives.
Supply and provision of services	• Community health volunteers play a critical role in the successful implementation for CHWks. Due to human resource limitations, the cadre is essential in delivering 'non-technical' services including the administering of VAS and Mebendazole.
Community perceptions	• Social mobilisation and community engagement are key in raising awareness of CHWk and encouraging utilisation of services offered. Using multiple methods of social mobilisation (including interpersonal communication, IEC materials and radio announcements) to target difficult-to-reach communities is particularly effective. Caregivers acknowledged the importance of regular attendance, appreciated the package of interventions, and perceived that CHWk services have a positive impact on child health in the community.
Issues of equity	• An equity-focused approach to CHWk has been adopted. This aims to ensure that services reach the most vulnerable children in the hardest to reach areas. The development of district microplans has enabled interventions and resources to be tailored towards engaging those most in need at the local level.

Recommendations

Despite the successes, a number of challenges remain and must be addressed to ensure the success and sustainability of the programme.

Human resources. The management of human resources for CHWks remains challenging. There is a shortage of staff available to implement CHWk at the lower levels and limited capacity at district level to manage resources. This has led to a high level of reliance on volunteers, who have become integral to the successful implementation of the campaign. It is imperative that the reliance on unpaid staff be addressed, specifically in relation to incentives and motivation, training and attrition.

Supplies. There is recognition that supply chain management needs ongoing strengthening as bottlenecks in the timely distribution of commodities to the district level undermine the planning processes and risk additional pressure being put on already strained resources.

Data management. The use of census data from the central statistics office to estimate commodity needs for CHWks, and for calculating coverage at local levels is problematic. Target populations are calculated as projections based on census data but do not allow for variations across areas. This complicates planning and reporting procedures, and has led to the overestimation of coverage. Although central statistics office data is used for national level reporting, local head count data enables a more accurate estimation of CHWk coverage at the district level, yet issues with denominators persist and contribute to data management challenges.

Transition. The health infrastructure in Zambia lends itself to the expansion of routine services with the eventual integration of key interventions that are currently delivered through CHWks. To ensure the equitable provision of services, and maintain high coverage levels whilst reaching the most vulnerable children, transition needs to happen gradually and in the context of broader health system strengthening.

	Recommendations
CHWk programme	• Addressing issues associated with the denominator used for the analysis of data is important for ensuring the quality and accuracy of planning and reporting. In parallel with the continuing development of data management capacity at sub-national levels, advocacy at the national level should encourage the reconciliation of denominators used during analyses.
Decentralisation and ownership	• Building on the political will for CHWk, the government should be encouraged to confirm their commitment to the campaign by allocating sufficient resources and ensuing the timely release of funds. Building on the successes of decentralisation, strengthening capacity at sub-national levels should continue, particularly in relation to planning and budgeting, and stronger accountability mechanisms should be integrated into the programme.
Coordination, supervision and training	• Coordination and resources should be enhanced to ensure that training and supportive supervision can be effectively cascaded to community-level actors, particularly in relation to data management. The importance of strong data collection needs to be (re-)emphasised and the reporting skills of community health volunteers and other personnel responsible for data entry should be increased. Whilst capacity has enhanced over recent years, it is critical that support for coordination, training and supportive supervision is reaffirmed. Sub-national actors must be empowered to assume responsibility and be accountable for the CHWk at their operational level.
Supply and provision of services	• Bottlenecks preventing the timely delivery of commodities for CHWks must be addressed. Mechanisms for the distribution of commodities must be strengthened so the timely release of commodities can be assured and the effectiveness of the CHWk programme is not jeopardised by supply-side issues. In parallel, capacity for human resource management at sub-national levels needs to be strengthened and clear staffing strategies put in place to ensure the provision of quality services during the campaign.
Community perceptions	• It is critical that targeted social mobilisation be continued and adequately resourced to build community trust and encourage the positive utilisation of CHWk services. This will help to overcome rumours and misconceptions, and facilitate ongoing engagement with difficult to access groups.
Issues of equity	• Building capacity and competency at provincial and district levels to access and interpret coverage data is essential. This would enable more evidence-based planning for CHWk that includes equity as a key component, and would strengthen the development of microplans that target the most vulnerable.

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