

# **INCEPTION REPORT**

## **The CHANGES Programme**

**Communities Supporting Health, HIV/AIDS, Nutrition, Gender,  
and Equity Education in Schools**

**Report Submitted to USAID/Zambia  
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## INTRODUCTION

The contract between USAID/Zambia and Creative Associates International Inc.(CAII) to implement the CHANGES programme was officially signed on 1 April 2001 (Contract HNE-I-00-00-00038-00). Funded for an initial period of three years, the CHANGES programme provides technical assistance to Zambia's Ministry of Education under the auspices of the Basic Education Sub-Sector Investment Programme (BESSIP). The overall aim of the CHANGES programme is to improve basic education in Zambia through the provision of technical support to three of BESSIP's nine focal points: Equity and Gender, HIV/AIDS, and School Health and Nutrition (SHN).

At the same time, the CHANGES programme aims to support USAID's Strategic Objective #2: *Improved quality of basic education for more school-aged children* through addressing two intermediate results: Improved participation of girls and other vulnerable children (IR 2.1) and Improved school-based health and nutrition interventions (IR 2.2). Cross-cutting these intermediate results are strategies to mitigate the negative effects of HIV/AIDS on the quality of, access to, and sustainability of good basic education and, as such, HIV/AIDS is a cross-cutting theme of the CHANGES programme as well. Another cross-cutting dimension or strategy of the CHANGES programme is a sub-grant mechanism, implemented in collaboration with CARE International, which aims to provide modest grants and seed money for projects and initiatives proposed by schools, PTAs, community groups, and local organizations in the areas of school health and nutrition, the promotion of basic education for girls and other vulnerable children, and the mitigation of the impact of HIV/AIDS on Zambian communities and its school system.

During the initial three-year period, the CHANGES program will be operational in Eastern and Southern Provinces, with its headquarters in Lusaka. In Eastern Province (hereafter EP) the central thrust is on school health and nutrition (SHN) interventions, including conducting baseline biomedical, anthropometric, and cognitive surveys; providing micronutrients and deworming pills to primary students, administered by teachers; training teachers in school health, nutrition, and life skills; community sensitization and mobilization through popular theatre, district field teams, and public gatherings; and strengthening linkages between health centers and schools.

Simultaneously, in Southern Province (hereafter SP) the focus of the CHANGES programme is the Community Sensitization and Mobilization Campaign (CSMC). Initiatives in this component include the use of popular theatre to facilitate community participation to surface issues related to increasing girls' and other vulnerable children's attendance and retention in primary school; the development and implementation of district- and community-level action plans to address issues raised through popular theatre and participatory action research; the training of provincial and district government officials in community participation methodologies related to gender equity; and training teachers to integrate life skills throughout the curriculum.

Although the SHN and CSMC components will be initially piloted in EP and SP respectively, it is anticipated that, over time, considerable cross-fertilization between the inputs being made in each province will take place. Further, inasmuch as addressing HIV/AIDS and providing small

grants cut across the two major component areas described previously, inputs in these two areas will be made in both EP and SP.

## PURPOSE AND STRUCTURE OF THIS REPORT

The purpose of this Inception Report, as delineated in the CHANGES programme Statement of Work (SOW), and required to be submitted to USAID three months after the arrival of the technical assistance team in Zambia, is three-fold:

- To verify the current status of the components that comprise the CHANGES programme (SHN, CSMC, HIV/AIDS, and Small Grants);
- To revalidate the life-of-contract Indicative Plan for each component;
- To provide more detail on targets to be achieved in the period from the arrival of the technical assistance team in Zambia to the end of the three-year time frame.

The report will be structured according to these three purposes or objectives for each component of the programme, starting with School Health and Nutrition (SHN), then moving to the Community Sensitization and Mobilization Campaign (CSMC), HIV/AIDS, and the Small Grants mechanism respectively. Comments on current status and suggestions for changes or adjustments in indicative plans and targets will be included for each report objective for every programme component under the heading “Assessment and Comments.”

## SCHOOL HEALTH AND NUTRITION (SHN)

### Current Status:

At present, the SHN component of the CHANGES programme is further along than the other components because considerable work was done by short-term consultants prior to the official signing of the CHANGES contract on 1 April 2001. Progress for most activities in the SHN component are on target for 2001 and onward though, in the immediate term, delays have crept in due to the Eastern Province Coordinator’s need to attend to an unfortunate family health matter which has taken him off site for more than one month at the time of writing. The following, excerpted from the Quarterly Report for April-June 2001 that was recently submitted to USAID/Zambia, highlights the status of, and progress made, in the SHN component:

***SHN Policy Development:*** During April the Eastern Province (EP) Coordinator reviewed comments received on the draft SHN document including those of participants of the National Symposium that was held in December 2000. A meeting of the SHN policy working group was called by the SNH focal point, and members who were present agreed they could proceed with formalizing policies only after they obtained clear guidelines on the correct format for policy documents from the Cabinet office. These format guidelines will be available in August. The working group also prepared for the planned workshop to develop an SHN manual by collecting documents and manuals available on water and sanitation, HIV/AIDS, and SHN (other country programs).

**Drug Procurement:** The EP Coordinator prepared a request in April to JICA (Japanese International Cooperation Agency) for support to purchase SHN drugs using their counter value fund facility. The details required of JICA included the type/brand of drugs, amounts required, and the time required. Also discussed in that meeting (attended by a consultant from Partnership for Child Development (PCD) as well) were issues such as the length of time required from proposal to release of funds, procurement procedures through the MOE, and possible restrictions on the use of the funds.

The EP Coordinator also met with Mr. S. Hakalima, BESSIP Director of Procurement and Supplies, to discuss MOE procurement and the impending drug order as a single source purchase. Further, they discussed the need to instate a tracking system to ensure that the drugs reach schools after distribution from Medical Stores to the districts.

In late June, the EP Coordinator and PCD consultant conducted follow-up meetings with JICA and the BESSIP procurement office to further plan for the receipt of the pharmaceuticals from JICA, which should take place in August 2001.

**Development of SHN Implementation Plan for 2001:** The EP Coordinator, in concert with counterparts from the BESSIP SHN Focal Point, developed a one-year work plan for headquarters and EP activities. The PCD consultant reviewed the work plan with regard to pilot activities, and provided more precise dates and indications of duration of activities. Additionally, a strategic planning meeting was held with the SP Coordinator in order to achieve a better understanding of community activities and time frames, which were then entered into the work plan. Cognitive assessment activities were also reviewed via correspondence by the Successful Intelligence (SI) consultant, and were later incorporated into the SHN work plan for 2001.

**Development of Indicators for the SHN Component:** Discussion of possible indicators for the SHN component of the CHANGES programme began in late 2000 when the EP Coordinator and SHN Focal Point Manager met with a consultant from the Academy for Educational Development (AED) to review possible indicators. As a result of that meeting, a list of 50 indicators arranged by category and grade level were drafted. A review of that list in April by the EP Coordinator and consultants from PCD and the World Bank, resulted in a more focused list of indicators that will be used to track progress in the SHN component of the CHANGES programme. (See Appendix A for this list of indicators.) This list will be further abbreviated to emphasize those indicators that can be used by BESSIP because the MOE will not be able to conduct biomedical or parasitological examinations.

**Biomedical and Anthropometric Baseline Surveys:** During 10-23 June 2001, a team of three consultants from PCD, in collaboration with the MOE and other local implementing partners, conducted a pre-validation survey of the instruments that will be utilized in Eastern Province to conduct the baseline survey in October 2001. The team conducted field studies in Chongwe District, Lusaka Province and had two objectives. The first objective was to develop, in the Zambian context, a tablet height pole to allow teachers to calculate the correct dosage of the drug praziquantel (used to treat bilharzia) for different children. The second objective was to field test a questionnaire method previously used in other African countries to indicate the prevalence with

*Schistosoma haematobium* in different communities. The heights and weights of 765 children in grades 1-7 attending six schools in Chongwe District were measured and the health questionnaire was administered to 72 children in each of two schools. The results of the studies will be used to finalize the tablet health pole and health questionnaire for use in EP starting in October 2001.

***Development of the Cognitive Assessment Instrument (CAI):*** The local SI consultant, based in the University of Zambia (UNZA), has continued work on developing the CAI that will be used in Eastern Province to measure learning achievement gains that result from the micronutrient and deworming interventions that will be made later in 2001 and beyond. In the US, draft items for the CAI were pilot tested in schools in the New Haven, Connecticut area. In Zambia, 100 core items were pre-tested, revised, and translated. Further, planning was conducted during May and June for the recruitment of field researchers, which was completed in July, who will administer the CAI, during both the validation process in July (presently underway) and the actual administration of the instrument in EP beginning in October 2001.

***Development of the School Health Card:*** During April and beyond, the EP Consultant continued to work with SHN Focal Point counterparts on redesigning the School Health Card, the design of which had been started in October 2000. The redesign incorporated suggestions received from teachers in Luapula Province, the MOH, and the Zambian Integrated Health Programme (ZIHP). The card was produced in two sizes with six folding sides. Pursuant to further suggestions for changes made by the BESSIP Management Implementation Team (MIT), additional modifications in the health card were made during May. The prototype School Health Card will be pilot-tested in a sample of schools and then evaluated after one year before being disseminated on a wider scale.

***Planning for Community Sensitization Through Popular Theatre:*** During April, the EP and SP Coordinators met with Professors Dixon Mwanza and Mapopa Mtonga of UNZA to discuss their potential collaboration on the community sensitization and mobilization dimension of both the SHN and CSMC components of the CHANGES programme. Discussions centered on issues regarding the importance of popular theatre, the arts, and community participation to motivate communities to support the work CHANGES is doing in EP and SP. Training methods and approaches were discussed, as well issues pertaining to the recruitment of popular theatre performers in both provinces. In May the EP Coordinator contacted and interviewed potential popular theatre groups who may be contracted for the community sensitization work to begin in EP in August.

At the end of June, Professor Mapopa participated in the CHANGES study tour to Malawi, a workshop conducted to orient 10 MOE and other key personnel to the model of community mobilization through popular drama that is being implemented in many communities in Malawi. Based upon this experience, the model will be adapted for its effective use in both EP and SP.

***Eastern Province SHN Situational Analysis Report:*** Research conducted by MEDOFF Systems during 2000 was finalized in report form and submitted in January 2001. However, due to dissatisfaction with the product that was submitted, a consultant was hired during May-June to edit the entire report, to write a condensed Executive Summary of the report, and to draft a brochure to promote the report. The consultant's inputs considerably improved the initial

document and was reviewed and approved in July. The reports and brochure will be made available to interested counterparts and collaborating partners and organizations when they are printed.

***Establishing a Physical Presence in Eastern Province:*** Although the CHANGES programme contract was officially signed on 1 April 2001, it was not until early May that the EP Coordinator arrived in Zambia with the intention of taking up residence in Chipata. Therefore, starting in late May (after the official launch of the programme), the EP Coordinator secured office space in the provincial MOE and established his residence in Chipata as well. Once settled, the EP Coordinator visited a number of NGOs and other organizations working in Chipata and other EP districts with a view to establishing links and working relationships and to avoid duplication of activities. An NGO coordinating group that meets quarterly already exists in EP, and CHANGES will be a part of that group. The EP Coordinator also met with provincial and district officials and the District Health Management Board with a view to establishing working relationships.

### ***Assessment and Comments:***

As stated previously, the SHN component of the CHANGES programme has had a running start due to the ongoing work of sub-contractors PCD and SI who, under separate “bridging” contracts, started their work well before the official signing of the CHANGES contract in April 2001. The work of both groups of consultants is on track at the present time and will continue to move forward as planned in the coming months and beyond.

In large measure, the effective and timely implementation of SHN activities has been facilitated by the fact that most of the SHN activities in the CHANGES annual work plan for 2001 are also part of the BESSIP SHN annual work plan. This integration has meant that the MOE is fully invested in the successful and timely implementation of the various CHANGES SHN activities, which is evident in the relative ease with which SHN activities are being planned and implemented, and supported by the MOE.

At the same time, however, the aforementioned unfortunate personal circumstances involving the EP Coordinator, requiring his departure from EP for an extended period of time during June and July, has resulted in delays in the community sensitization and mobilization dimension of the SHN component. Thus, when the EP Coordinator returns to Zambia in early August, significant efforts will be required to get the community participation side of the SHN component back on track.

### **Revalidation of Indicative Plan:**

Overall, the SHN component will achieve the following:

- (1) Demonstrate the effect of SHN interventions on pupil learning and behavior;
- (2) Demonstrate a model for mobilizing communities to support SHN for their pupils;
- (3) Strengthen the MOE’s capacity to design, deliver, and evaluate SHN programmes at school-, district-, provincial-, and central-levels; and

- (4) Develop a sustainable model for school-based SHN interventions that can be used for SHN programmes nationwide.

### ***1) Strategic Approach:***

As a strategic approach, the SHN Program will infuse four core principles throughout all programme strategies and activities: participation, communication, partnership, and capacity building.

**Participation** is both a means and an end to creating ownership, channeling resources, and targeting interventions that result in improved child health, nutritional status, and learning achievement. Success and sustainability will require the continuous active involvement and commitment at all levels of planning, implementation, management and monitoring of the SHN component. As such, active participation will permeate SHN activities across key public and private stakeholders, spanning all levels of planning, implementation and management (national, provincial, district, and community), including managers, implementers, and beneficiaries. The use of participatory strategies and methodologies is expected to secure significant levels of commitment and decentralization in SHN management and implementing capacity.

In addition, clear **communication** will sustain and characterize all levels of SHN activities. Effective communication systems, strategies, and methods will build understanding and promote action throughout the SHN component. Feedback loops will be established at all levels to ensure that communications remain clear, updated, and assure continuous learning and coordination. Through the employment of a variety of media and culturally appropriate communication styles, goals, objectives, roles, and responsibilities will remain sharply focused. To this end, the SHN component will support the agreement USAID helped broker between GlaxoSmithKline, the World Bank, and MOE for the development of a comprehensive IEC SHN scheme. It is anticipated that communication, approached in this manner, will create the synergy required for success and will have a positive ripple effect throughout the programme.

Cooperation, collaboration, and joint ownership will be best promoted, established, and maintained, across ministries, sectors, and levels of program planning, management and implementation through establishing **partnerships**. Different modes of partnering will be pursued in order to establish the most effective and sustainable modes of collaboration. These partnerships will be continually monitored and refined to keep them viable and achieving maximum performance goals and standards.

**Capacity building**—improved knowledge, skills and competencies—will be continually generated throughout the various SHN component levels and within all developmental phases so that key SHN competencies become embedded within appropriate planning, management, and implementation systems and personnel. Education and training strategies will emphasize utilization of active learning methodologies, competency-based planning and instruction, and performance monitoring as an integrated and reinforcing human resource development system. The SHN component will utilize organizational learning approaches so that capacity permanently resides within the MOE and with key governmental stakeholders.

## 2) *Conceptual Framework:*

The conceptual framework that undergirds the SHN component will be comprised of five successive reinforcing developmental stages—training, community-based sensitization, community interventions and advocacy, school-based interventions, and outreach and impact.

The SHN component process will be iterative with each action contributing to further actions that collectively and synergistically contribute to ever-increasing improvements and maintenance of child health. These stages, while appearing linear in their written description, are not necessarily sequential in their actual development and implementation and, in fact, will often overlap. Each of these stages is described in more detail below.

**Training:** Within the SHN component, training will be the main pathway to building awareness, participation, capacity, and action. Training is understood as broadly inclusive of a diverse range of educational strategies and methods that lead to positive changes in knowledge, attitudes, and behaviors in support of SHN component goals and activities. Training methods will include workshops, mentoring, coaching, meetings, focus groups, training classes, media, and communications. Training will occur continuously and at all levels of the SHN component:

- At the *national-/central-level*, training will include special meetings and training workshops of ministry officials and other key stakeholders to build awareness, knowledge, skills, and commitment to SHN activities.
- At the *provincial-level*, teachers at teacher training colleges will be instructed in SHN issues, health education methodologies, learning materials development and effective utilization. Teacher trainers and community development worker trainers will be trained in appropriate skills and methodologies to enhance their capacity. The anticipated end result will be the establishment of a sustainable modality for continuing both pre- and in-service training for future teachers and field workers.
- At the *district-level*, district managers and field workers (school inspectors, Resource Center coordinators, community development workers, and community health workers) will be trained in collaboration methodologies, community education and mobilization strategies, group participation techniques, rapid assessment tools, health and nutrition education methods, advocacy, and management skills.
- At the *community-level*, training will include meetings of formal and informal community leaders, community members and government field workers to discuss, analyze, and respond to child health issues and problems.
- At the *school-level* teachers will be training children in proper health and nutrition knowledge and practices.
- At the *child-level*, children will be sharing information and training their peers and families in appropriate health and nutrition practices.

**Community-based Sensitization:** Experience has shown that for a school health programme to succeed, the participation and commitment of parents/guardians, teachers and the community as a whole are imperative. Achieving this level of commitment requires community sensitization and advocacy—sensitization to understand the health status of their children and the circumstances and practices that contribute to such, and advocacy to facilitate their understanding of activities they can undertake and promote in order to increase the health status of their children. Through regular contact with communities, field workers will facilitate the process of identifying key groups and subgroups within the community and identifying possible social/cultural barriers to good health and nutrition interventions. While this process requires personnel and time, it is a necessary first step to assuring community acceptance, eventual ownership, and sustainability of identified interventions. Moreover, the process is intended to be ongoing and self-reinforcing, and to be internalized by the community without the need for further outside initiation or direction.

The various steps in the community-based sensitization process will be carried out by teams of field workers consisting of representatives from the three key SHN programme ministries: - Education, Health (MOH), and Community Development and Social Welfare (MCDSS). Having been trained in community participation methodologies and relevant health and nutrition concerns, these field workers will facilitate activities that help to support the overall SHN component goals. Initially the community-based activities will take place in all communities (80) being serviced by the selected pilot schools in EP.

Activities facilitated by the field worker teams are likely to include focus group discussions, informal meetings, household visits, and community mapping. The community will, in turn, identify situations they have the ability to alter using their own resources, or issues that require outside assistance and support to effectively tackle. For example, establishing a school garden might be well within a community's capacity while obtaining spare parts for broken hand pumps might require linkages with district officials (e.g., water resources) or NGOs that are in a position to assist. Facilitating communities to realize what they can accomplish on their own, as well as linking them to outside resources and information, will empower them to facilitate change.

Emphasis will be placed on working through existing committees within communities such as PTAs, neighborhood health committees, women's groups, and area development committees to develop plans of action that will identify key health and nutrition interventions to be undertaken by the community. The development of these action plans will ensure that the community as a whole has a plan to follow, target dates to meet, and recognition of who is responsible for particular actions.

**Community Interventions and Advocacy:** Due to the diversity of communities and the variety of circumstances that contribute to a child's health status, the range of activities identified in the action plans will vary. The activities and interventions will be implemented by community members themselves and may include such activities as: school feeding programmes, food production units, building or maintaining latrines, school cleanliness programmes, personal and home cleanliness regimens, organization of health/youth clubs, local newsletters, school open days, national immunization days, community peer counseling, formation of (or participation in) inter-sectoral committees (i.e. D-WASHE, PAGE, etc.), activities in promotion of school health

interventions, popular theater, and local radio broadcasts.

Achieving an understanding of communities, building trust and transparency through a community sensitization process, and developing and implementing community intervention plans of action will be essential for programme success. Parents will need to be advocates of the program by sending their children to school and by supporting teachers. Opinion leaders, health workers, religious leaders, and traditional leaders will also need to support the program and recognize the value of school-based interventions. The intended approach will take into account community diversity by involving subgroups and interest groups within the community (i.e. opinion leaders, traditional leaders, women, vulnerable groups, youth, etc.). Moreover, the approach will put decision-making in the hands of the communities by allowing them to set priorities and develop their own solutions. Equally important to ensuring programme acceptance and eventual ownership by communities will be the partnerships that are developed through the field outreach teams with communities.

**School-Based Interventions:** The SHN program will embrace interventions that, when delivered within an interactive and supportive framework of government and community partnerships, will form the basis of an effective school health and nutrition programme. Indeed, the international inter-agency initiative, *FRESH Start* approach, cites: (i) school-based health and nutrition services; (ii) skills-based health education; and (iii) the provision of safe water and adequate sanitation, as three of the four basic cornerstones of effective programmes. The fourth cornerstone—the implementation of school-based health policies—is currently being addressed by the Zambian Ministry of Education. These interventions will be key features of the strategy adopted by the CHANGES SHN component, and are described briefly below.

*School-based health and nutrition services.* As is common across most of sub-Saharan Africa, parasitic infections and disease are highly prevalent among the school age population in Zambia. The mass delivery of anthelmintics (deworming medication) and micronutrients are the most cost-effective, simple, and safe school-based health and nutrition services that can be delivered by trained teachers. Exhaustive operations research has identified cost-effective procedures for implementing all the above interventions. Additionally, teachers can be taught simple *illness recognition* skills. The ability to recognize simple physical signs of disease (e.g., overt signs of malnutrition) will help identify children with specific problems who can be referred to the local health center for specialist treatment.

*Skills-based health education.* This approach to health education focuses upon the development of knowledge, values, and life skills needed to make and act on the most appropriate and positive health-related decisions. Health in this context extends beyond physical health to include psychosocial and environmental health issues. Changes in social and behavioral factors have given greater prominence to such health-related issues as HIV/AIDS, malaria prevention, early pregnancy, accidents, violence, and substance abuse. These are factors that not only influence lifestyles, but also hinder education opportunities for a growing number of school-age children and adolescents. The development of attitudes related to gender equity and respect between girls and boys and among their teachers, and the development of specific skills, such as dealing with peer pressure, are central to effective skills-based health education and positive psychosocial environments. When individuals have such skills they are more likely to adopt and sustain a

healthy lifestyle during schooling and for the rest of their lives.

*Provision of safe water and adequate sanitation.* The school environment may damage the health and nutritional status of schoolchildren, particularly if it increases their exposure to hazards such as infectious disease carried by the water supply. Hygiene education is meaningless without clean water and adequate sanitation facilities, and it is a realistic goal to ensure that all schools have access to clean water and sanitation. By providing these facilities, schools can reinforce relevant health and hygiene messages, and act as an example to both students and the wider community. This in turn can lead to a demand for similar facilities from the community. CHANGES SHN activities with regard to safe water and adequate sanitation will be coordinated with related activities of others, for example, the WASHE activities supported by UNICEF in EP as well as other donor activities (JICA, GZT, Africare).

To effectively monitor and evaluate these school-based interventions, a management information system will be implemented. The revitalization of the School Health Card will be the action taken at the school-level to aid in this implementation process.

**Outreach and Impact.** First and foremost, the SHN Program is designed to have a positive impact on the health and nutrition of school-aged children, which will, in turn, contribute to improved pupil learning. Efforts to achieve this goal will focus on improvements in the child's physical well-being and immediate environmental conditions. The actions designed to support this goal, however, will require relevant inputs across the many spheres of organizational and individual support. The SHN programme will be a catalyst for change and, through advocacy and interventions, achieve both direct and indirect impact across the chain of individual lives, management structures and policy environments which shape and determine the quality of the child's life. Both the channels and strategies of outreach, as well as the anticipated impact of SHN interventions are described below for each level of action.

*Child-level.* The child is at the center of thought and action. Outreach to the child will extend through multiple complementary and reinforcing channels. Children will be recipients of beneficial pharmaceuticals that will directly improve their health status. They will also receive health education information that will raise awareness, create positive attitudes, and motivate change and action. Moreover, children will be challenged to join with teachers, parents, and community members in activities that promote improved health for themselves, their families, their friends, and their communities.

Examples of child participation and outreach are likely to include pupil health committees to monitor and assist in improving health conditions in the classroom and immediate school environments, drama groups formed which create plays focused on health needs, and peer outreach groups to engage out-of-school children.

Anticipated impacts will cut across child knowledge, attitudes, and behaviors. Health and nutritional status of children will improve which, in turn, will increase their cognitive capabilities. This will further lead to increased child attention, engagement, participation, and learning. Children will gain new knowledge about health and nutrition needs, problem solving, and critical thinking. As participants and leaders of interventions, children will develop

capacities in leadership, community organization, and group management. Further, children will improve their abilities to be peer and family educators and counselors.

*School-level.* Within the school, teachers will conduct a wide range of SHN activities. Foremost of these, teachers will be educators of children, imparting key SHN information, knowledge, and skills through improved school curricula, innovative and participatory teaching methods utilizing creative, customized communication tools, materials, and visual aids to reinforce instruction. The formation by teachers of partnerships with key student, parent and community groups will reinforce SHN knowledge and behaviors among all. Teachers will also dispense deworming medicine and nutritional supplements to pupils, monitor health status and make appropriate referrals as necessary. As such, the school itself will be an improved, healthy learning environment.

*Community-level.* Communities will similarly be used as a target of SHN outreach in seeking acceptance and active support of SHN activities. As described previously, community-level field workers from the MOH, MOE and MCDSS will form strategic alliances among and across teachers, key leaders, PTAs, NGOs, community groups, and local businesses to convene meetings and forums that lead to action focused on improving the conditions within which children live and grow. Local media will be used to impart reinforcing health and nutritional messages. Action plans will be developed and implemented with specific goals, targeted actions, and identified persons responsible for achievement. These action plans will be publicly shared and thereby become fora for building awareness and accountability.

The expected impacts will be diverse and far ranging. Community-based projects that contribute to improving child and community health status will be initiated and maintained. These may range from improved trash collection and water system maintenance to initiation of community campaigns or building key SHN messages and practices within local initiation practices. Community structures will be strengthened through active involvement and leadership on child health problems and issues. Capacity will be built within local leaders, community members and community groups as problems are tackled and responsive projects implemented. This will, in turn, engender confidence, empowerment, and forward momentum as other related, and perhaps more complex problems, are confronted.

*District-/provincial-level.* District- and provincial-level activities will be organized and managed, or pre-existing ones revitalized, to contribute to SHN initiatives. Cross-sectoral strategic alliances will be formed among MOE, MOH and MCDSS representatives, provincial-/district-level government officials, and local community development NGOs engaged in current or potentially related SHN activities.

Outreach will begin with senior government officials and managers to build awareness, "buy-in," and support for SHN initiatives. Subsequently, these senior officials will identify appropriate government personnel and district-/provincial- committees who will be mobilized to support and participate in joint SHN-related training, sensitization and planning activities. These alliances will catalyze and forge synergy and commitment through joint sharing of local resources such as offices and vehicles, and implementation of activities within which responsibilities are shared. Through these committees, accountabilities for SHN outreach and support will be established,

roles and responsibilities defined and assigned, structures and systems established, and appropriate supportive policies developed and refined. Further outreach will occur through use of district-/provincial-level media to introduce key SHN messages, build awareness, and reinforce support for SHN target interventions and activities.

In terms of impact, SHN capacity will be built within associated MOE, MOH, and MCDSS management systems, structures, and personnel. MIS systems will be established that inform better planning and decision-making. Inter-sectoral committees will be strengthened and, through them, key alliances fortified with district- and provincial-level NGOs working in related development areas. As field workers work and partner successfully with local schools and communities, their capacity to serve as effective change agents and advocates will, in turn, increase as a platform upon which future initiatives can be initiated. Further, the decentralized management of education and SHN initiatives will be reinforced and actualized.

*National-/central-level.* Outreach at the national-/central-level will mirror outreach undertaken at the provincial-/district-levels. The CHANGES SHN component will be fully integrated within the planning and operational structure of the MOE. As such, meetings will be called with key MOE stakeholders and officials for purposes of building awareness and aligning roles, responsibilities, and resources to support the SHN initiative. Under MOE leadership, outreach will continue through the established SHN Steering and Implementation Committees and the participating government, donor and NGO representatives to further organization collaboration, coordinate resources, develop and align policies, establish structures and generate other actions required to achieve SHN goals.

Positive impacts will similarly be registered across a wide range of associated areas. Most importantly, the government will have a piloted and proven SHN model for scaling up to national-levels, leading to potentially dramatic improvements in child health and academic achievement nationwide. Key stakeholder personnel will have increased SHN management and implementation knowledge and abilities. Cooperative management systems will be reinforced and institutionalized. National SHN information systems will be established and utilized as a strategic resource for shaping policies and directing resources to support the SHN program.

### ***3) Monitoring and Evaluation:***

To monitor the impact of the SHN program on developmental and educational outcomes, two types of indicators will be employed: cognitive/developmental indicators and educational indicators. Both types of indicators will be tracked at the group and individual level.

*Cognitive Development Indicators.* Work beginning in the early part of this century has shown an association between parasitic infection, under-nutrition, and poor mental development resulting in low school achievement. Multiple research studies have indicated that children with heavy infections and severely undernourished children display marked improvement in cognitive development following treatment. To monitor the impact of the SHN intervention on the children's cognitive development (and, subsequently, educational achievement) of the children, a Cognitive Assessment Instrument (CAI) will be developed.

The CAI will be characterized by construct validity, face validity, ease of administration, technological simplicity, low cost, noninvasiveness, ease and objectivity of scoring, short duration, cultural appropriateness, acceptability to the community, ease of creating parallel forms, flexibility across grade levels, and efficiency of measurement.

The CAI will provide indicators of most child-proximal dynamics in cognitive performance. Indicators of educational achievement are susceptible to the influence of many factors (e.g., quality of teaching, availability of textbooks, quality of school building, availability of teachers, teacher-student ratios), so that the child's health is only one of these factors. Therefore, to separate the variance in educational performance that is attributable to the health status of the child, the outcome indicators will be much more proximal to the child's individuality (i.e., those assessed by the CAI) than measures of educational achievement.

The CAI is curriculum and competencies-free. In other words, the CAI will be designed to be sensitive to changes in basic psychological functions relevant to learning (e.g., memory span, attention). The SHN interventions will strengthen these functions (e.g., expand memory span and improve attention) and result in gradual accumulation of knowledge and rising achievement scores. The SHN dimension, however, will not override teaching as a factor contributing to educational achievement inasmuch as, even when the child is in perfect health, high-quality teaching is necessary to bring about educational improvements.

*Educational Assessment Scores.* Students' school achievement is one of the main indicators of the long-term effectiveness of the BESSIP program. To monitor students' school achievement, the CHANGES programme will utilize batteries from the National Assessment of Education that are currently implemented by the Zambian Ministry of Education, specifically the Grade 5 National Assessment (G5NA).

This assessment has been selected as a monitoring indicator for students' school achievement for two reasons. First, the Examinations Council of Zambia possesses expertise in developing educational achievement tools and developed this instrument; it was tested in a large-scale field trial in 1999 and produced large quantities of interpretable data. Second, the Final Report on Zambia's National Assessment Project of 1999 produced no ceiling effect and the average scores were much lower than expected. Therefore, to explore the assessment's full potential, to investigate its psychometric properties on a large spectrum of performance, and to include higher performing students, it is advisable to use the assessment at higher-grade levels (grades 6 and 7).

In addition to monitoring pupil performance through cognitive and educational assessments, the CHANGES programme will monitor and evaluate progress of other important aspects of the SHN Program including inter-sectoral collaboration, capacity and skill development, management of data and use of data, teacher delivery of services and record keeping, pupil admission and attendance rates, pupil health and nutrition status, school/learning environments, and community participation. The indicators and mechanisms for monitoring these and other aspects of the SHN component have been developed (*see Appendix A*).

#### ***Assessment and Comments:***

The indicative plan, including the proposed strategy and conceptual framework, represent a

holistic approach to improving both the health and nutrition of children and enhancing their cognitive and learning achievement. The approach that will be employed involves multiple actors at all levels and, most importantly, empowers children, families, and communities to take charge of their own development. This being the case, the indicative plan, as proposed in the CHANGES SOW, is sound from a development point of view and is revalidated after three months of operations in-country.

However, two caveats need to be introduced. First, the indicative plan—in particular, the community sensitization and mobilization aspect—is complex and, therefore, it will be difficult to predict in advance the pace at which the work will proceed. This will be less an issue with the biomedical and anthropometric research, the establishing of baselines, the providing of deworming medication and micronutrients, and the measuring of cognitive achievement—all of which are clearly defined tasks that will be performed by outside consultants who come to Zambia for discrete periods of time to carry out those specific tasks. There is every reason to believe that those aspects of the overall SHN component will proceed as planned.

However, the community sensitization and mobilization aspects of the SHN component are inherently different in nature from the medical/scientific/research aspects. The work will be much less clearly defined and far fewer variables and realities that are involved will be under the control of the field teams, which will introduce uncertainty and an inability to predict outcomes. As a result, in terms of strategies and implementation plans, considerable flexibility and a willingness to try different, unplanned approaches may need to be tolerated. Thus, although the overall indicative plan for the SHN component is revalidated in this report, as the programme moves forward, changes in approach may be incorporated based upon extant realities as they are encountered.

The second caveat is that the proposed strategy, again especially on the community sensitization and mobilization side, is very labor intensive. Becoming acquainted with communities and earning their trust so that effective partnerships evolve between the field teams and the communities is a very time-consuming process for which there are no short-cuts. This raises the issue of sufficient staffing on the CHANGES programme. Although the intention is to integrate the CHANGES programme into the BESSIP, which suggests a sharing, borrowing, or seconding of MOE, MOH, and MCDSS staff at the provincial- and district-levels, early indications suggest that this will be problematic. For, either there are too few government counterparts available in the first place, or those who are available to work with the CHANGES team are too stretched with other tasks and responsibilities to be relied upon to work with on a daily basis.

In the original design of the CHANGES programme, provision was made to hire, on a contract basis, a local SNH technical advisor, a secretary, and a local training advisor who, with the Coordinator, would form the core team in EP. Unfortunately, however, prior to finalizing the CHANGES contract, at the request of the MOE, these positions were deleted. And the negative effects of this decision have been felt during the first three months of programme operation. Efforts are presently underway to restore those positions, and it is hoped that those efforts will be successful. If they are not successful or are delayed for a considerable period of time, there will undoubtedly be serious consequences for the SHN component.

## **Targets to be Achieved:**

The specific deliverables and tasks to be achieved in the SHN component during the first three years of the CHANGES programme, as detailed in the SOW, are the following:

**1. *Cognitive Assessment Instrument developed and implemented to measure the effects of health and nutrition interventions on pupil cognitive function.***

The Cognitive Assessment Instrument will provide data on the cognitive ability of students administered before and after the school health interventions, and will enable the programme to assess the relative success of the interventions on pupils' learning ability.

**2. *Studies/reports of findings regarding cognitive and achievement related to health and nutritional interventions produced.***

A study will be conducted to assess the impact of the SHN programme on the health and nutritional status of the children and on their learning capabilities.

**3. *SHN Programme Monitoring System developed and implemented.***

A participatory monitoring system will be put in place that collects and feeds back relevant information at six levels of the education system: child-level, including education and health status; school-level, including physical environment; educational level, including delivery of quality services; community-level, including community awareness and actions; district-level, including inter-sectoral collaboration and effective access and use of information systems; and central-level, including inter-ministerial collaboration, management and use of data for decision-making.

**4. *Evaluation reports produced and disseminated.***

The reports to be written and distributed include the following:

- *Mid-term evaluation of programme progress:* This report will assess the processes, systems, and achievements of the first three years of the programme (this, on the assumption that the CHANGES programme will be extended beyond the initial three years.) The lessons learned will serve as a springboard for scaling up in the remaining years.
- *Final programme evaluation:* The final evaluation will occur at the end of the programme and will be used to inform policies at the national-level.
- *Impact assessment:* Periodic assessments based on indicators to measure expected outcomes for both education and health at each level of programme intervention will be conducted.

**5. *Policy and planning deliverables:***

- School Health and Nutrition Policy Document.

- Letter of Understanding between the MOE and MOH for SHN activities.
- SHN Strategic Plan.
- SHN Curriculum Document.
- Jointly developed plans at national-, provincial-, district-, and/or school, zonal-, and village-levels for implementing SHN activities (between MOE, MOH, CBOH, MCDSS, and/or other ministries or sectors).
- Model of collaborative action across ministries operational in the GRZ.

**6. *Community participation deliverables:***

- Community-level organizations formed to address SHN, Equity and Gender, and/or HIV/AIDS issues.
- Community-level action plans developed and project activities based on the plans implemented in 80 primary school catchment areas.

**7. *System for community-based data collection and use designed and implemented.***

A model for collecting, reporting, and using community-generated as well as MOE EMIS-generated education information reports to make good education decisions at all levels will be put in place in the pilot districts of EP and SP. At a minimum, the model developed will be implemented in the communities of the 80 primary school catchment areas of EP and 45 primary school catchment areas in SP. Moreover, the capacity for using and implementing the model will be built among district-level officers in all districts of both provinces.

**8. *The SHN programme, especially for school-based deworming and micronutrient interventions, will be successfully implemented in up to 80 pilot schools. The programme includes the delivery of the following:***

- Improved pupil cognitive capabilities, learning, health and nutrition.
- Central-level ministry officials and other key stakeholders aware of and committed to the SHN programme.
- The SHN programme fully integrated within the planning and operational structure of the MOE.
- Effective IEC (Information, Education, and Communication) and media utilization strategy operating to deliver SHN messages and reinforce support for SHN.
- Sustainable pre- and in-service SHN teacher and field worker training programs put in place. (This includes Teacher Training College, tutors, teacher trainers, and community development worker trainers who are trained in SHN issues and appropriate skills and methodologies.)
- Sixty or more district managers and field workers (school inspectors, Resource Centre coordinators, community development workers, and community health workers) trained in collaboration methodologies, community education and mobilization strategies, group participation techniques, rapid assessment tools, health and nutrition education methods, advocacy, and management skills.
- Strategic alliances formed through community-level field workers' facilitation.

- Community leaders and other members provided with opportunities to discuss, analyze, and respond to child health issues and problems.
- Community-based projects initiated and maintained in 80 school catchment areas.
- Approximately 720 teachers (nine per school involved in the pilot) trained in proper health and nutrition knowledge and practices including simple illness recognition skills and physical signs of disease and making referrals for medical attention, and to effectively deliver the interventions (deworming medication and micronutrients).
- Children learn appropriate health and nutrition practices, including age-appropriate lifeskills and HIV/AIDS-related skills and knowledge for maintenance of appropriate behaviors and/or change to healthier, safer behaviors. Children are provided with skills-based health education including psychosocial and environmental health issues to promote positive social and behavioral formation and/or change and peer counseling skills.
- Teams of SHN field workers formed (including representatives from the MOE, MOH, and MCDSS).

**9. *Based on the outcomes of the pilot test, a plan will be developed to successfully scale the SHN programme to include pupils in all primary schools in Eastern Province (approximately 540 schools).***

**10. *HIV/AIDS-related activities including plans of actions and implementation of projects based on those plans occurring in communities of at least 80 primary school catchment areas in Eastern Province.***

**11. *SHN management information system implemented. This includes reintroduction and use of pupil School Health Cards.***

**12. *Establishment of a drug storage and distribution system.***

***Assessment and Comments:***

Due to unforeseen tragic circumstances involving the family of the Eastern Province Coordinator, the technical assistance team has not had the opportunity to carefully re-evaluate the above targets in time to submit this report.

On the other hand, in discussions with the MOE, SHN counterparts suggested that deliverable #9 be reworded to include not only the development of a plan for taking SHN interventions to scale in EP but that the plan also be *implemented* during the initial three-year period of the CHANGES programme. The same counterparts also suggested that in deliverable #8 more than 720 teachers be trained, including teachers from other districts in EP and even other provinces. While the urge to move more quickly and to include greater numbers of beneficiaries is understandable, in the present case it should be resisted. There are at least three reasons for this.

First, due to the labor intensive nature of the work and the relative unavailability of manpower, as described previously, it is not realistic to expand the current targets in the deliverables during the initial three-year period. The fact that the original duration of the CHANGES programme was reduced from five years to three years is significant in this regard, and must be borne in

mind. Second, the medical and cognitive assessment dimensions of the SHN component are being conducted according to a strict experimental design, including control and intervention groups, and, therefore, in order to preserve the integrity of the research being conducted, the scope of the interventions must be limited and controlled. Third, the initial three-year period of the CHANGES programme is a pilot phase during which research will be conducted and interventions will be made and evaluated on that basis. Until the results are derived from the research (including determinations of appropriate dosages of medications and micronutrients to be administered) and until the efficacy of the medical interventions on cognitive and learning achievement are established, it would be irresponsible to dispense medications widely to many children.

For these reasons, it is recommended that the targets remain as they are for the initial three-year period. Assuming the research supports the overarching hypothesis that appropriate administration of deworming medication and micronutrients to children will result in a measurable positive improvement in their cognitive ability and learning achievement, it would be appropriate, indeed necessary, to scale up those interventions throughout EP and even throughout Zambia. It is hoped that the CHANGES programme, as provisionally planned, will be extended after three years to be a part of that scaling-up process.

As far as the training of teachers is concerned (deliverable #8), in theory there is no restriction on the MOE/BESSIP training more teachers in EP or in other provinces in Zambia. If this were done, CHANGES would play a supporting, not leading role, because its budget does not provide for training teachers beyond the number (720) specified in the SOW. At the same time, however, if the provision of micronutrients and deworming pills are not provided to schools and children beyond those participating in the pilot in EP in the initial three-year period, it would not be advisable to train teachers from schools not participating in the pilot. This is because the training is closely linked to the provision of pharmaceuticals and, if those drugs and micronutrients are not dispensed soon after the training, the training is not likely to have much meaning or efficacy at the time it is delivered.

Regarding the targets established for community sensitization and mobilization within the SHN component, including the development and implementation of general action plans (deliverable #8) and HIV/AIDS action plans (#10), as noted previously, it is difficult to predict the pace at which the work will proceed and what are likely to be the outcomes of that work. Because it is too early to gauge the pace at which communities will be genuinely sensitized and mobilized, and how they will respond in terms of developing and implementing action plans, at present there is no basis upon which to suggest changes in targets. What is important, however, is that all concerned are cognizant of the inherent unpredictability of this type of work and that that understanding result in a flexibility about targets and numbers of beneficiaries should that be necessary as the SHN component moves forward.

## COMMUNITY SENSITIZATION AND MOBILIZATION CAMPAIGN (CSMC)

### Current Status:

The CSMC component of the CHANGES programme has not had the advantage of many inputs being made prior to the signing of the CHANGES contract, compared to the SHN component and, as a result, less has been achieved to date. The following, excerpted from the first Quarterly Report (April-June 2001) recently submitted to USAID/Zambia, describes the current status of the CSMC component:

***Site Visits to Southern Province:*** In April, the SP Coordinator, with the Programme Manager from Creative Associates International's home office in Washington, DC, made two visits to Southern Province to begin laying the groundwork for starting the CHANGES programme there. During these visits, they determined tentative site locations for activities, secured office space in the provincial MOE, and held a number of meetings with key personnel in the MOE, MOH, and MCDSS to begin planning for implementing the CHANGES programme.

***Development of 2001 Implementation Work Plan:*** Also during April, the SP Coordinator participated in four sessions with key BESSIP Equity and Gender Focal Point personnel to develop the CSMC component CHANGES work plan for 2001, spanning April through December.

***Development of Indicators for the CSMC Component:*** At the same time the 2001 CSMC work plan was developed (above), indicators to track progress were also established in collaboration between the SP Coordinator and Equity and Gender counterparts in the MOE headquarters. *(See Appendix A for a list of the performance indicators and the means by which progress will be verified.)*

***Planning for Community Sensitization Through Popular Theatre:*** As stated previously in relation to the SHN component, the EP and SP Coordinators met with Professors Dixon Mwanza and Mapopa Mtonga of UNZA in April to discuss their potential collaboration on the community sensitization and mobilization dimension of both the SHN and CSMC components of the CHANGES programme. Discussions centered on issues regarding the importance of popular theatre, the arts, and community participation to motivate communities to support the work CHANGES is doing in Eastern and Southern Provinces. Training methods and approaches were discussed, as well issues pertaining to the recruitment of popular theatre performers in both provinces. At the end of June, Professor Mapopa participated in the CHANGES study tour to Malawi, a workshop conducted to orient 10 MOE and other key personnel to the model of community mobilization through popular drama that is being implemented in many communities in Malawi. Based upon this experience, the model will be adapted for its effective use in both EP and SP. (For more on the Malawi study tour, see below.)

***National-Level Orientation and Sensitization Meeting:*** On June 1, 2001 a meeting was held at the Andrews Motel in Lusaka to officially launch the CSMC component of the CHANGES programme at the national-level. Approximately 30 people attended the meeting representing, in

addition to the MOE Headquarters, the MOE in Southern and Eastern provinces, MOH, MCDSS, CARE International, UNZA, and USAID. Although the bulk of the day was spent introducing the methodology that will be used for the CSMC in Southern Province, time was also allocated to providing the participants with an overview of the CHANGES programme, including the SHN, HIV/AIDS, and small grants components. During the meeting, a video of the community sensitization and mobilization methodology employed in Malawi was shown, and this generated considerable discussion on how the model can best be adapted for use in Zambia.

**Malawi Study Tour:** During 24-29 June, a group of 10 persons, including the SP Coordinator, four BESSIP Focal Point persons, four MOE representatives from SP, and one UNZA professor attended a training workshop in Malawi. This initiative represented an important starting point in launching the CSMC component in SP. The workshop was organized and delivered by CRECCOM (Creative Centre for Community Mobilisation), a local NGO in Malawi. The aims of the workshop were, first, to familiarize the participants with CRECCOM's Social Mobilization Campaign (SMC) methodology and, second, to provide participants with practical experience in SMC so that they can adapt the methodology to the situation in Zambia. As such, the workshop combined theory with practice, and served to orient both senior-level MOE personnel as well as those closer to actual implementation to the methodology that will be used in SP to motivate communities to support girls' education and to address the ravaging effects of HIV/AIDS on their families, communities, and schools. It is anticipated that the Malawi study tour will catalyze work in community sensitization and mobilization for both CSMC and SHN components of the CHANGES programme.

**Planning for the Launch of the CSMC in Southern Province:** Initially, it was intended that the provincial launch of the CSMC would take place two weeks after the national launch on June 1, 2001. However, due to several circumstances, including the late arrival of the SP Coordinator, it was decided to delay the provincial launch until after the Malawi study tour. Much of the planning for the provincial launch has been completed in terms of determining the venue, the individuals who will be invited, and the approximate cost. It is anticipated that the provincial launch will take place in August 2001.

**Establishing a Physical Presence in Southern Province:** The SP Coordinator arrived in Zambia to begin her long-term assignment approximately one month after the EP Coordinator and the Senior Technical Advisor arrived. After spending approximately two weeks in Lusaka to participate in the national launch of the CSMC, to conduct planning with BESSIP counterparts, and to procure items for her residence, the SP Coordinator relocated in Livingstone. There, she began outfitting her office in the provincial MOE, started laying the groundwork for launching the CSMC with provincial MOE counterparts, and set up her residence.

#### **Assessment and Comments:**

As stated previously, there is less happening "on the ground" in SP because the work effectively started in June 2001 when the Coordinator took up residence in Livingstone. No antecedent work was done in this component prior to the signing of the CHANGES contract in April, unlike the SHN component. For this reason, it will take longer for the CSMC programme to gain traction and to bear tangible results.

Two major constraints to progress in the CSMC component have manifest themselves in the three months since the inception of the CHANGES programme. The first is the same difficulty described in the SHN section of this report regarding lack of personnel. To date, the Coordinator of the CSMC component in SP has found it extremely difficult to make progress in planning and beginning activities due to the chronic unavailability of counterparts with whom to work in the provincial MOE. Therefore, in this case, as with the SHN component, the removal of the budgetary provision to hire contract staff to work with the Coordinator has had a deleterious effect on progress. Hopefully, this situation will be rectified and approval to hire some contract staff to work daily with the Coordinator will be given by USAID as soon as possible.

A second constraint, related to the first, is that none of the activities in the CHANGES CSMC work plan for 2001 are in the BESSIP annual plan. As a result, because relevant MOE counterparts are already stretched to their limits by the other BESSIP-related tasks for which they are accountable to implement, working on CHANGES activities is sometimes not a priority which, naturally, exacerbates the first constraint regarding insufficient manpower. While there may be little that can be done to rectify this situation for the remainder of 2001, it does underscore the critical importance of developing the BESSIP and CHANGES annual work plans for 2002 (and subsequent years) in a collaborative and synergistic fashion so that there is genuine integration of the plans and a concomitant sense of investment and ownership on the part of all concerned.

### **Revalidation of Indicative Plan:**

The overall strategy employed in the CSMC, in terms of its underlying values and guiding principles, will closely resemble that of the SHN component, described in the previous section of this report.

#### ***1) Strategic Approach:***

In its strategic approach, the CSMC will infuse the same four core principles as the SHN programme throughout all campaign activities—participation, communication, partnership, and capacity building.

**Participation** is both a means and an end to any successful mobilization campaign. Success and sustainability require the continuous active involvement and commitment at all levels of planning, implementation, management and monitoring. As such, active participation will permeate all aspects of the CSMC, across key public and private stakeholders, spanning all level of government management (national, provincial, district, and community), and including facilitators, planners, implementers, and beneficiaries.

Clear **communication** will sustain and characterize all levels of the CSMC. Through the employment of a variety of media and culturally appropriate communication styles, goals, objectives, roles and responsibilities will remain sharply focused. Community strategies will most likely include, but will not be limited to, radio programmes, newsletters, public fora, and school-based supplementary learning materials.

Cooperation, collaboration and joint ownership will be best promoted, established, and maintained, across ministries, sectors, and levels of programme planning, management and implementation through establishing **partnerships**. Different modes of partnering will be pursued in order to establish the most effective and sustainable modes of collaboration. These partnerships will be continually monitored and refined to keep them vibrant and achieving maximum performance goals and standards. Key partnerships will be established between and among various line ministries (MOE, MCDSS, MOH), central authorities and schools, teachers and students, and teachers, parents, and communities.

**Capacity building**—improved knowledge, skills and competencies—will be continually generated throughout the CSMC. Ministries will explore ways of strengthening their collaboration and cooperation. District-level officials will increase their skills and abilities to coordinate, manage and facilitate community-based activities and community members will increase their capacity to identify and solve problems and overcome social, cultural, and economic constraints. In addition, the capacity of a variety of community groups and NGOs will be strengthened to offer continued support in the promotion of girls' education and the alleviation of factors contributing to the spread of HIV/AIDS.

## **2) Conceptual Framework:**

The CSMC conceptual framework contains five successive reinforcing developmental stages—research and verification, training, community-based sensitization, community-based interventions, and outreach and impact.

The CSMC will embody an iterative process whereby each action (or stage) contributes to further actions that, in turn, collectively and synergistically contribute to ever increasing improvements in the participation of girls' and vulnerable children in basic education and in the decline of practices that contribute to the proliferation of HIV/AIDS. Each of these stages is described in more detail below.

**Research and Verification:** The research for the CSMC will be carried out in a participatory fashion, facilitated by a team of skilled action researchers and dramatists. Research will be conducted at selected sites and achieved by having the research team live among the community members for 7-10 days, talking, observing, and sharing in order to ascertain the main constraints to education for girls and other vulnerable children and the main factors that contribute to the proliferation of HIV/AIDS in the community. As key issues emerge, they will be woven into a drama script that will be performed before the community on the team's last day on site. The drama performance will be participatory in nature, allowing the community to take part in the dialogue and in some cases, to modify the course of the script. In this way, drama will be used not only as a "mirror" of community behaviour, but also as a means of verifying the reality of what is portrayed. This method, often referred to as *Theatre for Development*, has proven to be an effective and inclusive means of community-level research and verification.

**Training:** Within the CSMC, training will be the primary conduit for building awareness, participation, capacity, and action. Training is understood to be broadly inclusive of a diverse range of educational strategies and methods which lead to positive changes in knowledge,

behaviours, and skills in support of the CSMC goals and activities. Illustrative training methods include workshops, mentoring, coaching, meetings, focus groups, training classes, media, and communications. Training will occur continuously at all levels of the CSMC. However, the key training event will take place at the conclusion of the research and verification phase in each district, with the knowledge gained during that phase providing the basis for the training of district-level officials from the three line ministries.

**Community-based Sensitization:** Experience has shown that for any mobilization campaign of this nature to succeed, the participation and commitment of parents/guardians, teachers, local leaders, and the community as a whole are imperative. Achieving this level of commitment requires community sensitization, dialogue and involvement. This component of the conceptual framework will be facilitated by the trained district-level officials in teams. Each team will consist of at least one member from each of the line ministries—Education, Health, and Community Development and Social Services. Having been trained in community participation methodologies, and aware of the relevant issues that are surfaced as a result of the research and verification phase, these officials will facilitate activities that help to support the overall CSMC goal.

Importantly, the community-based sensitization component of this CSMC is intentionally collaborative: it is anticipated that no single field worker will initiate or implement the process without the presence of their colleagues from both the other key ministries. This is intended to demonstrate and model joint collaboration and cooperation and to illustrate that addressing issues surrounding education for all and the impact of HIV/AIDS requires multiple perspectives and inputs.

**Community-based Interventions:** Due to the diverse nature of communities and the variety of circumstances that limit girls' education and contribute to the spread of HIV/AIDS, community-based interventions will be as diverse as the communities themselves. This dimension of the CSMC is where communities will exemplify their commitment to change. In some cases the commitment will be demonstrated in what appear to be small ways—for example, sending their girls to school instead of to the market—and sometimes it will be demonstrated through apparently larger efforts—for example, assisting in the installation of pit latrines at the school site. Community-based interventions will be the core of this dynamic process; they will most likely be incremental and create the basis out of which will arise new challenges and opportunities.

**Outreach and Impact:** First and foremost, the CSMC is designed to have a positive impact on the education of girls and other vulnerable children and to help recognize the causes of, and to stop, the proliferation of HIV/AIDS. The CSMC will reach out to school-age children but, through its methodology, will also embrace the school, the community, the district, and the province. In the end, measurable change should ultimately occur to support performance indicators such as a decrease in girls' and orphans' drop out rates and an increase in girls' and orphans attendance, an increase in pupil assessment scores, an increase in net admission rates, and an increase in retention rates.

***Assessment and Comments:***

The Indicative Plan, as summarized above from the CHANGES SOW, is appropriate and revalidated at this time. Having said that, however, the model upon which the plan is based was developed in Malawi and, therefore, it is possible that some adaptations and modifications of the overall strategy will need to be made to fit the Zambian context as the CSMC process moves ahead in SP. Because the field teams are only presently being formed and have not yet started work in the villages, it is difficult to identify what those adjustments in the model will be. In any case, changes in the overall approach, if they are made at all, are likely to be minor.

The same observation that was made with regard to the community sensitization and mobilization dimension of the SHN component is worth repeating with regard to the CSMC: the model is very labor intensive. In the case of the CSMC component, field teams and drama troupes will be working in villages for 7-10 days, which means that considerable manpower and support will be required by the concerned ministries, especially at the district-level, to ensure that the work proceeds smoothly and in a timely manner. The issue of meeting the established targets will be addressed below.

**Targets to be Achieved:**

According to the SOW, the CSMC component will achieve two broad aims:

- 1. Sensitize, motivate, and mobilize parents, local leaders, teachers, pupils, and PTAs from every school catchment area in nine districts in Southern Province to increase girls' and other vulnerable children's enrolment and retention in primary school and to halt the proliferation of HIV/AIDS.***

Under this broad aim, the CSMC will achieve the following targets:

- At least nine of the eleven districts in SP will be actively involved in the CSMC.
  - Forty-five schools (five per district) and approximately 360 villages will be involved in action research and verification activities.
  - Community-level plans of action will be developed and implemented in nearly every community in the initial nine districts in SP.
- 2. Strengthen the capacity of district-level officials from the MOE, MOH, and MCDSS to work cooperatively and collaboratively, and to facilitate a successful mobilization campaign.***

The following targets will be achieved under this second broad aim:

- Approximately 270 (30 per district) district officials from the MOE, MOH, and MCDSS will be trained in community participation methodologies and mobilization strategies.
- Approximately 90 (10 per district) district-level plans of action will be developed as a framework for community sensitization and mobilization.

**3. *HIV/AIDS-related activities, including plans of action, developed and small projects based on those plans implemented in 45 primary school catchment areas.***

***Assessment and Comments:***

Because the CSMC component of the CHANGES programme has a necessarily emergent quality in terms of the specific outputs or outcomes of the community sensitization and mobilization process described above, it is more difficult to anticipate and predict in advance the targets that will be achieved. Therefore, the targets identified in the CHANGES SOW are less clearly defined than in the SHN component. The overall process the CSMC will pursue in communities, however, can be revalidated.

With regard to specific targets, there are two proposed changes. First, given the labor intensive nature of the particular model of community sensitization and mobilization the CSMC will employ and the long distance between villages, the target of involving 360 villages in the research and verification activities in a three-year period is unrealistic. A more achievable target is 270 villages (30 per district) based on a calculation of approximately six villages per school, five schools per district, and nine districts. This being the case, 270 community-level plans, rather than 360, will be developed and implemented in the villages involved in action research and verification. The actual community involved in the action plans may be larger than the village that participated in the action research because the definition of “community” will depend on factors such as common land and interests, common schools, and issues shared by villages.

The second modification in targets stems from the SP Coordinator’s perception that the target of training 270 district-level officers from the relevant line ministries is similarly over-ambitious. The observations and personal contacts the SP Coordinator has made so far suggest that there are not 30 district-level officials even posted in district offices. A more realistic figure would be 10 district officials trained per district for a total of 90 district-level officials. Five in each district will be from the MOE, and will be the “lead” for each district-level action plan that is developed, and the other five officials from each district will be from the MOH and MCDSS. In addition to the 90 district-level officials, 180 community animators will be trained to bring the total to the original 270. These 180 field workers will be comprised of four persons from each of five school catchment areas (for example, PTA members, community health officers, elders, women’s leaders, etc.) in nine districts. They will be trained in community mobilization skills and to take the lead in developing and implementing action plans.

As mandated in the SOW, 45 district-level action plans, centered on each school catchment area, will be developed and implemented, and each of those action plans will have an HIV/AIDS component.

## **HIV/AIDS**

### **Current Status:**

HIV/AIDS is a cross-cutting theme in the CHANGES programme rather than a discrete component. However, due to the increasing attention HIV/AIDS is receiving from USAID/Zambia and the likelihood of its taking on increasing prominence in the CHANGES

programme moving forward, it will be addressed as an entity in itself in this Inception Report as well as in all Quarterly Reports submitted to USAID in the future.

The following describes the current status of HIV/AIDS inputs in the CHANGES programme as described in the recently submitted Quarterly Report:

***The Impact of HIV/AIDS on the Education System:*** On April 12, 2001 the EP Coordinator and consultants from PCD and the World Bank met with the MOE Director Planning and several statisticians to discuss the impact HIV/AIDS is having on Zambia's education system. During this meeting they examined computer models for assessing the current impact of the pandemic as well as projections of the impact in the future. On June 18, 2001 much of the data in hand were presented and discussed in a half-day meeting at the Holiday Inn, attended by personnel from the CHANGES team. One unfortunate outcome of that meeting was the realization that there continues to be considerable denial about the impact of HIV/AIDS on the teaching force and on the education system in general because data presented were at considerable variance with data from other sources. This suggests that considerably more work needs to be done in assessing and publicizing the ravages of HIV/AIDS on Zambia's education system and devising strategies for mitigating those negative effects.

***HIV/AIDS and the CSMC National-Level Launch:*** Although the June 1<sup>st</sup> national-level launch focused on the CSMC component in Southern Province, because HIV/AIDS is a cross-cutting theme, considerable time was allocated for a presentation by the BESSIP HIV/AIDS Focal Point Manager on BESSIP's 2001 annual work plan for HIV/AIDS and the potential interface with the CHANGES programme. After the presentation, participants brainstormed issues and challenges that are likely to arise in communities with regard to addressing HIV/AIDS through the CSMC process.

***Development of Life Skills/HIV/AIDS Training of Trainers Course:*** BESSIP SHN Focal Point personnel, collaborating with representatives from the Curriculum Development Centre and UNICEF, developed a framework for a Life Skills training of trainers course and requested that the CHANGES programme agree to support with funding the implementation of the course. However, in the view of the CHANGES team, the framework presented was too general (covering topics such as effective communication skills, problem solving, personal confidence, etc.) to be effective for bringing about behavioral change in youth with regard to HIV/AIDS. Therefore, initially CHANGES hesitated in supporting the initiative. In a meeting with the SHN and HIV/AIDS focal points on June 11, 2001, attended by the CHANGES Senior Technical Advisor and consultants from PCD and the World Bank, the same feedback was reiterated. The outcome of this meeting was that the SHN team was willing to focus the life skills training specifically on HIV/AIDS as the carrier for introducing the other more general topics and, as a result, the CHANGES team expressed its willingness to participate in the refocusing on the training course and to allocate resources for the training of trainers course.

***Participation in USAID's Multi-Sectoral HIV/AIDS Initiative:*** HIV/AIDS is taking on increasing prominence in USAID's overall strategy for Zambia and, as such, USAID has adopted a multi-sectoral approach to dealing with the pandemic. During June, USAID called two meetings attended by its HIV/AIDS and Orphans Working Group (HOW) and implementing

partners. In the first meeting, the multi-sectoral approach it is adopting was presented and, following the presentation, representatives of the implementing partners introduced themselves and briefly described the work they are doing in HIV/AIDS, especially in Southern Province. The aim was to begin to think about synergies that already exist between projects and programmes, or that might be forged in the future, for mitigating the effects of HIV/AIDS.

The second meeting, held approximately one week later, was a brainstorming session attended by many of the same individuals. In that session, more concrete steps were taken to highlight potential linkages and avenues for collaboration between the various implementing partners. The CHANGES Senior Technical Advisor participated in both meetings and offered ways in which the CHANGES programme might collaborate with other projects and programmes, not only in SP but also in EP. As the CHANGES programme continues to move forward, it is anticipated that these linkages will become more formalized and that genuine collaboration with other organizations and projects will emerge.

#### ***Assessment and Comments:***

The HIV/AIDS cross-cutting “component” of the CHANGES programme is on schedule, though few concrete activities will appear on the ground until the community sensitization and mobilization work in the SHN and CSMC components gains a foot hold and begins to progress. In the meantime, efforts are being made to situate the CHANGES programme within broader discussions and plans that are being developed to address HIV/AIDS in general, for example the USAID multi-sectoral initiative, in order to begin advanced planning to ensure integration and collaboration with other projects and initiatives once concrete activities begin to emerge within the CHANGES programme in EP and SP.

#### **Revalidation of Indicative Plan:**

There is no indicative plan as such for the HIV/AIDS dimension of the CHANGES programme because it is a cross-cutting theme. As described in the SHN and CSMC sections of this report, the issue of HIV/AIDS will be addressed frontally in those components and, as part of the community mobilization activities in each of those components, action plans that focus specifically in HIV/AIDS will be developed. In EP, such plans will be developed and implemented in 80 catchment areas around selected pilot schools, and in SP 45 community plans to address HIV/AIDS will be developed and implemented in primary school catchment areas of the nine districts included in the CSMC pilot programme. The precise nature of those action plans and the small projects and initiatives that will be designed and implemented based on those action plans cannot be specified in advance in this report because, in the interest of making HIV/AIDS inputs demand-driven, they will emerge through the expressed needs of communities in the community sensitization and mobilization activities described under the SHN and CSMC previously.

#### ***Assessment and Comments:***

The strategy to have HIV/AIDS cut across the SHN and CSMC components, and for specific activities, small projects, and initiatives to emerge through the community sensitization and mobilization process is appropriate and will be pursued by the CHANGED programme. Because HIV/AIDS is a very personal and sensitive issue, it is appropriate that interventions, as much as

possible, be based upon the expressed needs of the individuals, families, and communities affected by the pandemic.

Having said that, however, the CHANGES programme will pursue, to whatever extent is practicable, a second avenue for addressing HIV/AIDS, one that is not exclusively need-based and demand-driven. That is, the CHANGES programme will support activities and initiatives in the BESSIP HIV/AIDS Strategic Plan that was recently developed as they appear in the BESSIP annual work plans for 2001 and 2002 and, even possibly, 2003. These will be activities like teacher training courses (for example, the proposed life skills training), working with health care workers to address HIV/AIDS, media campaigns, and policy development.

At first blush, pursuing this more top-down approach would appear to be at odds with the decidedly bottom-up approach proposed in the CHANGES SOW (and revalidated in this report) and, to some extent, this is true. Yet there are at several reasons why taking this dual-track approach is recommended.

First, as suggested previously, it will take time for the community sensitization and mobilization work in EP and SP to gain traction, which means it will take time for action plans to address HIV/AIDS at the community level to be developed and implemented. Given the seriousness of the HIV/AIDS problem in Zambia and the urgency with which it needs to be addressed, waiting for the community work in CHANGES to produce tangible fruit will result in valuable time being lost in addressing the pandemic. Therefore, while the community sensitization and mobilization work in SHN and CSMC is being planned and getting started, pursuing this other track will be prudent.

Second, in light of the inherently unpredictable nature of community mobilization in terms of what will be included in action plans, the CHANGES programme cannot assume that all, or even many, communities will respond forthrightly to the need to address HIV/AIDS. In other words, the sensitization and mobilization process with regard to HIV/AIDS may be only marginally successful, or not successful at all, in some communities and localities. Should this turn out to be the case, considerable time would be lost and the opportunity to make other non-need-based inputs would also be diminished if other programming modalities are not pursued in the meantime.

Third, community development experience in many countries suggests that localized, community-based initiatives tend to wither on the vine if they are piecemeal and are not supported by broader structural mechanisms and an awareness on the part of the general population that can nourish and sustain them. For this reason, it will be appropriate—while the localized community sensitization and mobilization work is being done—that teacher and health worker training in HIV/AIDS awareness, social marketing campaigns, and policy development efforts are supported. These are the types of activities proposed in the BESSIP HIV/AIDS Strategic Plan that the CHANGES programme will collaborate with and help to implement in addition to the more localized community mobilization that is at the heart of the CHANGES strategy.

## **Targets to be Achieved:**

Few specific targets for HIV/AIDS are included in the CHANGES SOW. In EP, the life skills training that is conducted will have an explicit focus on HIV/AIDS and, as described above, community action plans to mitigate the effects of HIV/AIDS in communities and on the school system will be developed and implemented in 80 school catchment areas. In SP, 45 such community action plans will be developed and implemented.

### ***Assessment and Comments:***

The specific targets in the SOW, as described above, are appropriate and will be the axis around which CHANGES HIV/AIDS inputs will be planned and implemented. However, as suggested in the previous section, a dual-track approach will be pursued whereby support will be provided to appropriate initiatives generated apart from the communities themselves that, in the view of the CHANGES team, will help to reinforce and support the work that is done in the communities. These initiatives will be those proposed in BESSIP HIV/AIDS annual work plans or initiatives being implemented by other projects and organizations in EP and SP that have synergy with the work being done in communities by CHANGES.

## **SMALL GRANTS MECHANISM**

### **Current Status:**

Insofar as the small grants mechanism is also, in a sense, a cross-cutting entity, it is not a component that will operate in isolation from the other three components of the CHANGES programme. Further, because the provision of small grants to communities, local organizations, and PTAs will take place through the community mobilization activities in the other components, this piece of the programme will only take definition and become operational after the other components are well underway. In that sense there will be a time-lag in the provision of small grants in the early going of the CHANGES programme. The following, included in the Quarterly Report recently submitted to USAID/Zambia for April-June 2001, outlines the current status of the small grants mechanism that will be implemented in collaboration with CARE International:

***Planning Meetings with CARE International:*** Two meetings were held with key CARE personnel during this reporting period. On May 8 the Programme Manager from CAII's home office, the EP Coordinator, and the Senior Technical Advisor met with CARE to orient their staff to the CHANGES programme and to discuss the subgrant mechanism in broad terms. In a follow-up meeting on May 30, further planning was done in terms of discussing the possibility of shared office space in the Livingstone CHANGES office, the procurement of a vehicle, and other more general logistical matters. In a brief discussion with CARE's Assistant Country Director, the Senior Technical Advisor of CHANGES was informed that CARE has hired staff to oversee the subgrant component of the overall programme.

***CARE International Participation in the CSMC National-Level Launch:*** During the June 1<sup>st</sup> national-level launch, time was allocated to CARE to present information on their existing subgrant programme and to discuss issues of collaboration with the CHANGES programme. Part of

the presentation outlined the criteria CARE uses to award grants in their existing sub-grant programme and how the overall process works. This was useful information for the participants because it is anticipated that many of the same processes will define the awarding of grants in the CHANGES programme.

### ***Assessment and Comments:***

As amply noted, the provision of small grants will flow from the community sensitization and mobilization work done in EP and SP and, therefore, will become operational later than the other three components of the CHANGES programme. This being the case, things are on track at the present time inasmuch as the groundlaying work is being done regarding establishing collaborative mechanisms with CARE International while the community work becomes operational in the other components. But more work needs to be done to finalize implementation modalities, and this will be accomplished so that the grants can begin to be provided at the appropriate time. Most of this planning with CARE will be done by the Lusaka-based staff in the weeks and months ahead while the field teams “prepare the soil” in the communities in the provinces.

### **Revalidation of Indicative Plan:**

The purpose of the small grants mechanism, as described in the programme SOW, is to enable communities, local NGOs, and other non-profit organizations to undertake or expand innovative interventions that (a) increase the participation and learning of girls and other vulnerable children in education; (b) support or improve innovative SHN activities to improve learning, health, and nutritional status among school-age children; and/or (c) integrate HIV/AIDS awareness and prevention messages to promote life skills and appropriate behaviors into ongoing school-, community-, and district-based basic education activities.

The sub-grant mechanism is not intended to be an end in itself; rather, the provision of grants will be programmed, where appropriate, in conjunction with technical assistance, training, and/or other programmatic inputs toward the achievement of specific objectives that respond to expressed local needs and contribute to meeting CHANGES’s objectives, indicators, and targets.

It is anticipated that the small grants will fall into two broad categories. First are *Rapid Response Grants*, below \$10,000 in total cost, for time-bound, activity-specific needs such as conferences, workshops, training sessions, or specific community or school needs (for example, pumps for wells, solar panels for electricity, support for Interactive Radio Instruction (IRI) centers, and so on). Second are *Mid-Level Grants* of one to three years, valued between \$10,000 and \$100,000, for longer term activities by more experienced NGOs.

In the national-level launch of the CSMC component held on 1 June 2001 (see above section on current status), CARE International gave a presentation on how it is managing its existing small grants programme, including training in proposal writing for prospective awardees, criteria that are used to determine the provision or non-provision of grants, and the monitoring process once grants have been made. Although more collaborative planning needs to take place between CHANGES and CARE personnel in regard to this specific small grants programme, it is

anticipated that many of the same processes and procedures CARE is currently employing in its existing grants provision programme will be used in the CHANGES small grants programme.

***Assessment and Comments:***

Although a number of implementation details are yet to be worked out, the overall indicative approach/plan for the provision of small grants to communities, local NGOs, schools, and PTAs will be pursued as outlined in the SOW.

**Targets to be Achieved:**

According to the SOW, USAID/Zambia estimates that approximately 10-20 Rapid Response Grants will be made annually and approximately 2-3 Mid-Level Grants will be made annually. Importantly, the CHANGES programme (and, by extension, CARE International) will not be judged according to how many grants are issued in a given period, and there are no results related to the sub-grant mechanism piece of the overall CHANGES programme.

***Assessment and Comments:***

As is the case with the other components of the CHANGES programme, because the community sensitization and mobilization process is unpredictable, it is difficult to speculate with any degree of accuracy about the number and sizes of small grants that will be made. Of particular concern are the larger Mid-Level Grant in terms of the capacity of local NGOs to responsibly programme and manage grants of that size. Having said that, the estimates of numbers of grants made by USAID appear reasonable and will be used as targets.

It is likely, however, due to the amount of time it will take for community mobilization efforts to result in the development of action plans, that few, if any, grants will be made during 2001 and that the pace will move more swiftly every year going forward. Prior experience with small grants programmes suggests that artificially accelerating the pace of providing grants without laying the necessary ground work in terms of sufficiently sensitizing, training, and mobilizing communities has a deleterious effect on both the success of the small grant projects and the overall community development process.

**CONCLUSION**

CHANGES is a very interesting and worthwhile programme, one that takes into account much of what has been learned about sustainable development in recent decades. It is a decidedly need-based and demand-driven programme that empowers stakeholders at every level to take charge of their own development rather than waiting for development inputs from outsiders who do not know their issues and problems as well as they do. The programme, in the case of the SHN component, combines research to establish the validity of interventions that are made and, in the case of the CSMC component, develops and refines innovative models for enabling communities to identify their needs and to address those needs. It is a multi-subsectoral programme that adopts a holistic and integrated approach to improving the quality and efficacy of primary education in Zambia, an approach that is necessary because the underlying issues and challenges have multiple causes and, therefore, cannot be addressed in a piecemeal fashion. Naturally, not all inputs that need to be made to improve basic education in Zambia will be made by the

CHANGES programme because no one initiative can tackle such a vast terrain. The substantive areas in which the CHANGES programme is not working are being addressed by other projects and programmes.

One thing that should be clear from this Inception Report is that, as appropriate and well-conceived as the CHANGES programme might be, it will not be easy to implement. By definition, empowering individuals and communities and being responsive to their expressed needs, requires relinquishing control of not only the products of development but also, to some extent, of the process as well. For this reason, throughout this report the notions of emergence and evolution have been prominent, along with their close cousin: the inability to clearly specify targets and outcomes in advance. The challenge will be for the CHANGES team to balance process and product, emergence with achieving results, and responsiveness with accountability.

Further challenges in implementing the CHANGES programme will arise from the complexity of its design. Working with three BESSIP Focal Points simultaneously, as has already been learned, will be a difficult juggling act that will require patience and understanding on the part of all concerned. And this challenge will be magnified by the fact that the CHANGES programme is a “Case 4” initiative in the MOE rather than one that is directly integrated as part of the “basket” of overall MOE operating funds. Further, the fact that the programme will collaborate not only with the MOE but also the MOH and MCDSS will test the commitment and collaboration skills of all concerned. And, lastly, that there are three sub-contractors—CARE International, PCD, and SI—adds additional administrative, management, and logistical layers to the programme.

Geographical distances between Eastern and Southern Provinces and Lusaka, difficulties in communications, and the inability of field and headquarter staff to meet and confer on a regular basis will test everyone’s patience, as has already been learned after three months of operation. But, perhaps the challenge that looms largest is that of insufficient manpower, as addressed in several sections in this report. The work CHANGES will be doing is labor intensive and cannot simply be willed to be done or be done by remote control. For the programme to succeed, sufficient human capacity—both on the programme side and on the part of the government—will need to be provided and, as necessary, developed to achieve the ambitious targets and deliverables set forth in the CHANGES SOW. The challenges are considerable but so is the commitment to face and surmount those challenges in the interest of improving basic education and the overall quality of life of the Zambian people.

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## **Appendix A**

### **Indicators for SHN and CSMC Components**

**SHN INDICATORS BY CATEGORY/LEVEL**

<b>Category/level</b>	<b>INDICATOR</b>	<b>Means of Verification</b>	<b>STATUS</b>
<b>Child Quality Measures</b>			
1. Education	Increase in cognitive assessment scores	Cognitive Assessment instrument delivered by teachers	Baseline scheduled for Oct. 2001
2. Health	Reduction in worm infection prevalence	Biannual parasitological assessment	Baseline scheduled for Oct. 2001
3. Nutrition	Increase in haemoglobin levels	Biannual Biomedical-assessment	Baseline scheduled for Oct. 2001
<b>WATER</b>	% of schools with access to safe water on premises	Survey Reports	Discussions with UNICEF and other potential partners ongoing
<b>SANITATION</b>	% of schools with latrines available by gender	Survey reports	Discussions with UNICEF and other potential partners ongoing
<b>COMMUNITY</b>	% increase of PTAs/ communities supporting SHN interventions with specific action plans	Survey reports	Discussions with UNICEF and other potential partners ongoing
	% of PTA group meeting regularly/ at least X times a year		Activities scheduled to begin in June 2001
<b>TRAINING</b>	# of teachers trained in School-based health and nutrition interventions	Reports	Training to begin in July 2001
	# of teachers trained in HIV/AIDS life skills	Reports	Training scheduled for Sept. 2001
	# of children who have received the set number of health education lessons	Reports	Numbers to be assessed in April 2002
	# of children who have received the set number of HIV/AIDS life skills lessons	Reports	Numbers to be assessed in June 2002

### CSMC PERFORMANCE INDICATORS

Priorities/category	Performance Indicator	Means of Verification
1. Participation of girls & other vulnerable children in basic education	Increase in % of enrolment & retention rate of girls & other vulnerable children in basic education	Yearly school record.
2. Sensitization & mobilization	Number of schools, communities, local leaders, PTAs and pupils sensitized and mobilized concerning HIV/AIDS and girls/vulnerable children's education	Reports
3. Gender & Equity	Number of provincial/district officials sensitized & trained in gender & equity issues in education	Reports
4. Action Research	Number of communities participating in Action research	Diaries/field reports
5. Participatory Training at all levels	Number of national, provincial and district level officials (field workers) trained in Participatory methodologies.	Reports
6. Research & Verification	<ul style="list-style-type: none"> <li>▪ Number of community members present to verify research</li> <li>▪ Number of TFD performance for verification of research</li> </ul>	<ul style="list-style-type: none"> <li>▪ Reports/diaries</li> <li>▪ Reports</li> </ul>
7. Participatory monitoring	<ul style="list-style-type: none"> <li>▪ Number of communities' activities (as mentioned in action plan) monitored</li> <li>▪ Number of communities monitoring their own progress</li> </ul>	<ul style="list-style-type: none"> <li>▪ Quarterly Monitoring reports</li> </ul>
8. Life Skills	Number of teachers(schools) using life skills modules in primary grades	Monitoring reports.
9. Communication	Use of variety of communication media focused in promoting girls and other vulnerable children's education and in sensitizing community members (including teachers, children) about HIV/AIDS proliferation and its mitigation.	Variety of Communication media in place
10. Action Plan	<ul style="list-style-type: none"> <li>▪ Number of action plans developed by districts</li> <li>▪ Number of communities developing community action plan</li> </ul>	<ul style="list-style-type: none"> <li>▪ District action plans</li> <li>▪ Community action plans</li> </ul>
11. Capacity-building at all levels	<ul style="list-style-type: none"> <li>▪ Number of district-level officials able to facilitate community-based activities in participatory ways</li> <li>▪ Number of communities able to identify their needs, prioritize them, and take action to meet those needs.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Reports</li> <li>▪ Reports</li> </ul>