SARAI

Sexual And Reproductive Health for All Initiative

PROJECT DISSEMINATION

2015 TO 2020

Ministry of Health

USAID FROM THE AMERICAN PEOPLE

Society for Family Health Better Choices. Healthier Lives.

psi

ChildFund International

DAPP DEVELOPMENT AID FROM PEOPLE TO PEOPLE ZAMBIA

PROJECT GOAL

To increase the modern contraceptive prevalence rate by 2% annually through increased access to improved quality of FP/RH services

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EXECUTIVE SUMMARY

Lack of access to family planning services and quality of care are major constraints to increasing family planning use in Zambia. In this light, USAID awarded the Family Planning and Reproductive Health Project to increase the Modern Contraceptive Prevalence Rate (mCPR) in all women of reproductive age and improve the quality of family planning services. The project was called the Sexual and Reproductive Health for All Initiative (SARAI) led by the local organization Society for Family Health (SFH) Zambia with a consortium of partners and implemented from 2015 to 2020 in 173 sites in 17 districts in Copperbelt (6), Muchinga (6) and Luapula (5) provinces. Expanding services called for innovation and a package of comprehensive approaches. It was identified that community-based distribution of family planning products and services would increase uptake of contraceptives and contribute to task-shifting away from facility staff. The community-led approach allowed 1,102 community based distributors (CBDs) to provide short-term family planning methods and messages. They increasingly attended to clients with 48,325 FP visits to CBDs in 2016 to 290, 000 in 2019, on average 20,000 monthly. The CBDs maintained a retention rate of 94% on FP. Compared to facility based providers, CBDs saw more youth clients. SARAI worked with youth friendly spaces (YFS) to compliment efforts that had been made to improve services for adolescents and youth by the Ministry of Health (MoH). SARAI refurbished select youth friendly spaces, trained adolescent champions and trained providers in adolescent friendly health services in order to respond to the underserved population.

Dedicated Family Planning providers were engaged in high volume facilities while they were off-duty. This model was a complimentary strategy to the existing systems increasing the uptake of contraceptives by expanding the hours of operation of FP service and accounted for an average of 15% of all FP services provided in SARAI supported districts. In order to maintain high standards of FP/RH services SARAI established a robust Quality Assurance (QA) system. The project adopted PEPFAR QA tools for assessments of the supported health facilities. Key QA performance indicators were formulated and assessed. QA assessments at end of project indicated that 97% of facilities were adherent to the set QA standards. FP/RH services were offered comprehensively and integrated with other clinics (ART, TB, Antenatal, VCT, OPD and IPD). SARAI trained 167 public sector health care providers in FP integration service delivery and oriented provincial and district health management teams on family planning integration. Strengthening MOH use of data for decision making was also a hallmark of the project.

By the end of the project, 16 model districts were established meeting the criteria of 50% of their health facilities encompassing the key components and systems needed, at the community level, to respond effectively to the family planning needs of the population. Overall the project surpassed its goal of increasing district-wide mCPR by 2% annually achieving an average increase of 4% annually implementing the above mentioned strategies. SFH Zambia is humbled to be the prime partner that worked with the MoH and other strategic implementing partners on this important project. A special thanks goes to the project staff, health facility staff and community volunteers for their involvement and contribution to the expansion of FP/SRH services in Zambia. It is our hope that quality FP/SRH services will continue to be provided building upon the project learnings reaching those most in need.

BACKGROUND

The Government of the Republic of Zambia (GRZ) through the Ministry of Health (MOH), are committed to improving the health of women, adolescents, and their families. In particular, GRZ has committed to increasing modern contraceptive prevalence among married women from 33% to 58% by 2020 as part of the global FP2020 effort, and has taken concrete steps to achieve this goal through MOH's Costed Eight-Year Integrated FP Scale-Up Plan 2013-2020. In line with this effort, USAID awarded the flagship project known as the Sexual and Reproductive Health for All Initiative (SARAI) dedicated to family planning with a goal to increase the modern contraceptive prevalence rate by 2% annually.

The project was implemented in Zambia from April 2015 to June 2020 by the local organization, Society for Family Health Zambia (SFH) and a strong team of partners namely, Development Aid from People to People (DAPP), Child Fund and Population Services International (PSI). It aimed to achieve the stated goal through 1) improving family planning services delivery, 2) strengthening accountability of Family Planning service delivery systems, and 3) increasing health Family Planning and reproductive health practices. The project supported 173 health facilities in 17 districts of Zambia in Copperbelt (6), Luapula (5), and Muchinga (6) Provinces. The initial project design included establishment of model districts which was defined as one with at least 50% of supported facilities in select districts meeting model health facility criteria.

In line with the project work plan, project staff participated in international, national, provincial and district level meetings, workshops and conferences exchanging successes and lessons in fora such as the International Conferences on Family Planning and HIV, exchange visits on DMPA-SC, various country level Technical Working Groups, data review meetings and planning meetings. Project staff also participated in the launch of key national documents such as the National Implementation Plan for DMPA. The project successfully held regular semi-annual review meetings throughout the life of the project to review project performance, challenges, sharing of best practices, and devised project plans.

Project staff were placed within each province and select positions seconded to the provincial health office. While most project staff were clinically trained, their role was mainly to provide complementary mentorship and supervision to the MOH staff working in Sexual Reproductive Health/Family Planning (SRH/FP), improving their capacity to deliver high quality health services. PSI provided key technical input into quality assurance, youth programming and sub-award management. Project performance was regularly shared with USAID via semi-annual portfolio review meetings, monthly meetings, joint site visits and reports. Through sharing, it was realized that quantifying mCPR would prove difficult without annual household surveys, therefore the project developed a methodology to be used as a proxy for calculating district-wide mCPR based on distribution of FP methods. It is through this lens that SARAI was implemented using a multi-pronged strategy described in further detail in this document.

ACRONYMS AND ABBREVIATIONS

AE	Adverse Events
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARVs	Antiretroviral drugs
CBD	Community Based Distributor
CPR	Contraceptive prevalence rate
DAPP	Development Aid from People to People
DIM	District Integrated Meeting
DMPA-IM	Depot Medroxyprogesterone Acetate Intramuscular EA Enumeration area
ELITE	Empowering Leaders in Teamwork and Equality
EQA	External Quality Audit
FP	Family Planning
GLOW	Girls Leading Our World
HIV	Human immunodeficiency virus
HMIS	Health Management Information Systems
IEC	Information Education Communication
IGA	Income Generating Activities
IPD	In-Patient Department
LARC	Long Acting Reversible Contraception
mCPR	Morden Contraception Prevalence Rate
MEC	Medical Eligibility Wheel
MOH	Ministry of Health
OPD	Out Patient Department
OVC	Orphans and Vulnerable Children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief

PIM	Provincial District Integrated Meeting
PP_PREV	Priority Populations Reached with the standardized Preventive Messaging
PSI	Population Services International
QA	Quality Assurance
RM&E	Research Monitoring and Evaluation
SARAI	Sexual and Reproductive Health for All Initiative
SRH	Sexual and Reproductive Health
STI	Sexual Transmitted Infections
TB	Tuberculosis
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Treatment
WHO	World Health Organization
YFS	Youth Friendly Space
ZAMFAMP	Zambia Family Project
ZDHS	Zambia Demographic and Health Survey

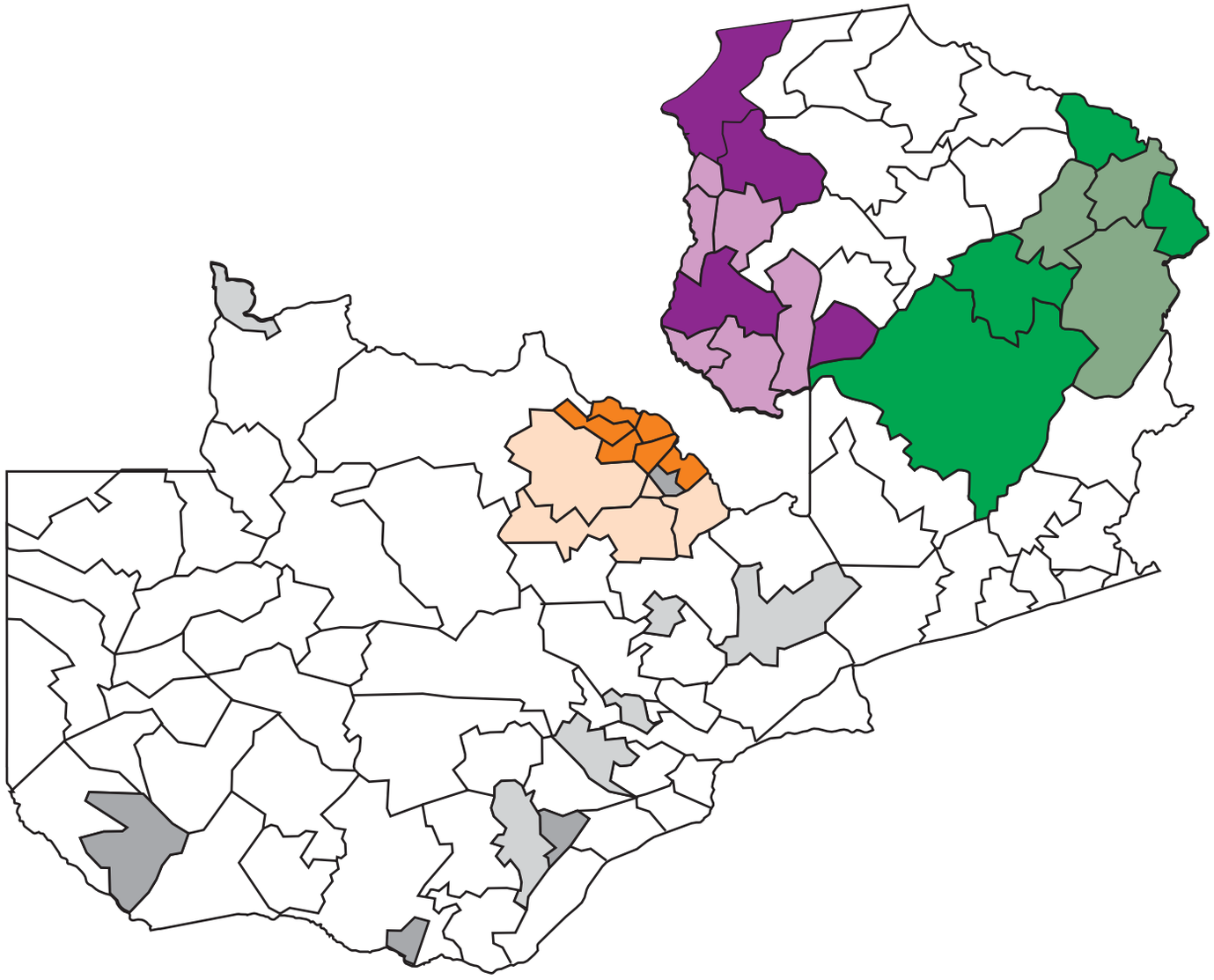
OPERATIONAL AREAS

Project sites

Copperbelt Province
Chililabombwe
Chingola
Kalulushi
Kitwe
Mufulira
Ndola

Luapula Province
Chienge
Kawambwa
Lunga
Mansa
Nchelenge

Muchinga Province
Kanchibiya
Lavushi Manda
Mafinga
Mpika
Nakonde
Shiwang'andu



FAMILY PLANNING SERVICE DELIVERY IMPROVED

Former SFH Country Representative (Second from left) with CBDs in Muchinga Province

IMPROVED METHOD MIX THROUGH ENHANCED COMMUNITY BASED AND FACILITY SERVICE DELIVERY MODELS FOR FAMILY PLANNING

Community-based distribution model: Community-based distribution of family planning products and services was identified as one of the mechanisms through which the uptake of contraceptives would be increased. It has been documented that incorporating community workers shifts the burden of basic health services away from more highly trained health workers. Shifting tasks to lesser-trained, less-expensive cadres improves access to services with constrained budgets. As such, SARAI adopted this community-led approach to expand family planning services.

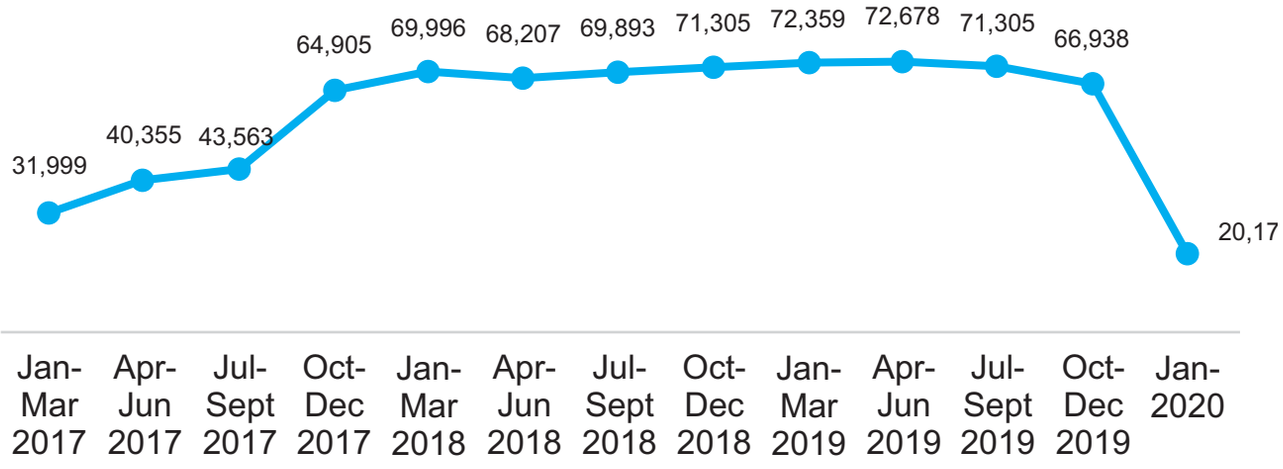
The selection of Community-Based Distributors (CBD) for each facility catchment area was carried out by the community with oversight of health facility staff. Deliberate criteria were adopted in order to have CBDs who are in good standing in their respective communities and would provide a linkage between the facility and the community. Each SARAI supported health facility selected an average of 6 CBDs to cover specific zones. The selected CBDs were initially trained in order to create awareness and generate demand for FP as well as distribution of oral contraceptives and condoms. Trainings were cascaded from the Training of Trainers at national level to training of CBDs and their supervisors in each of the three supported provinces.

Following the authorisation by the Ministry of Health for the scale up of use of CBDs in administration of Depot Medroxyprogesterone Acetate Intramuscular (DMPA-IM) in 2016, SARAI in collaboration with ChildFund, and building upon their previous work, proceeded to roll out CBD trainings to equip them with competent skills to provide injectable contraceptives of DMPA in their respective communities. The initial trainings were conducted in the model districts of Kalulushi, Kawambwa and Mafinga. The scope of trainings was expanded in 2017 when SARAI was the first to pilot the introduction of a subcutaneous version of DMPA. CBDs played a pivotal role during this successful pilot, which contributed to the authorisation for nationwide roll-out of DMPA-SC by the Ministry of Health. The project increasingly scaled up to new facilities from the initial 88 in 2015 to 173 in 2020. As such the number of CBDs trained also cumulatively increased from 531 in 2016 to 1,102 against the target of 1,135 by the end of the project making it the largest network in Zambia of community health workers providing FP services. Although 97% of the target was achieved, the remaining 3% represents CBDs that did not met the set criteria to complete the training.

CBDs contribution to district data for FP commodity distribution as reported in the national HMIS reached as high as 75% across the years while combined oral contraceptives peaked at 81% in 2018. Overall annual average contribution for short-term contraceptive methods increased from 26% in 2016 to 61% in 2020. In

Client (left) with CBD (right) at a Health Facility

Figure 1. Number of FP Clients provided with services by CBDS



Source: Project Data

addition, CBDs were able to reach more youth than their facility counterparts with 49% of their clients being under the age of 25 years.

Although the CBDs were purely volunteers, as a way of encouraging economic empowerment, SARAI, through Development Aid from People to People (DAPP), introduced a revolving Income Generating Activity (IGA) loan for CBDs amounting to approximately $150 per CBD per loan cycle to pursue a venture of their choosing. For sustainability reasons, management and supervision of the IGA loan was the responsibility of staff in-charge at each health facility. CBDs were also equipped with reporting tools and other essentials (i.e bicycle, chitenge, back packs, reflector vest, project t-shirt, gum boots and raincoats).

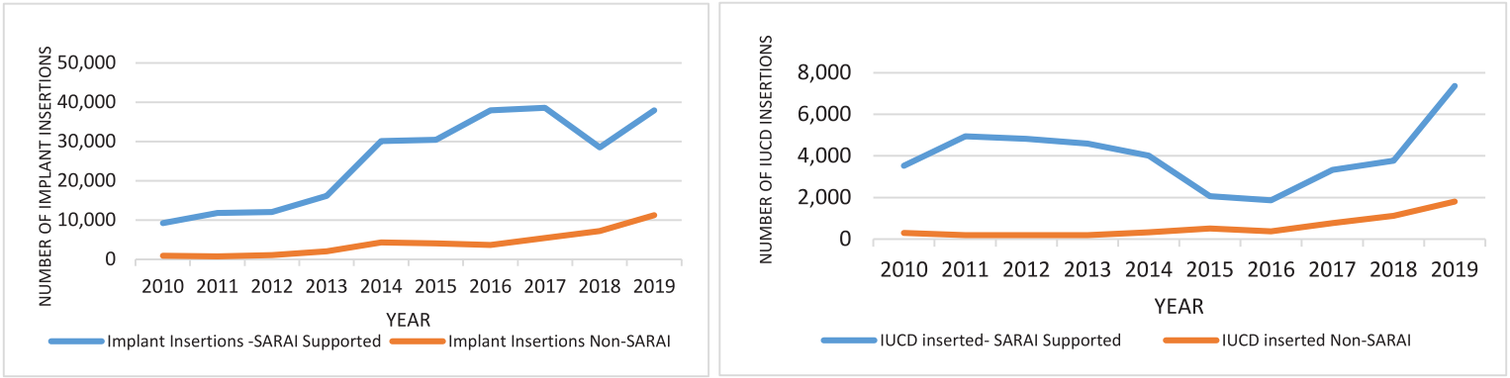
CBDs now form an integral part of the MOH system and report directly to the health facility. The support provided to CBDs and their high standing within the communities has resulted in a remarkably high retention rate (94%) of CBDs providing FP services after one year post-training. With 58% of the health facilities supported by the project being rural, the use of community workers was key to expanding sustainable FP services to those previously underserved.

Off-duty provider model: In order to achieve uninterrupted provision of FP/RH services, SARAI engaged dedicated FP/RH providers on an off-duty basis. This intervention was referred to as the 'off-duty model'. The model was a complimentary strategy to collaborate with existing systems in increasing the uptake of contraceptives. In order to ensure comprehensive services were provided, the project trained MoH staff in LARC service provision. The number of LARC providers trained by SARAI in supported facilities progressively increased from 100 providers in 88 facilities in 2016 to 233 in 173 facilities by 2020. In addition to skills capacity building for providers, SARAI provided LARC insertion and removal equipment to all supported facilities. Project motor vehicles, whenever available, were dispatched to facilities to ease movements during outreach sessions.

Off-duty providers strategically targeted high turn-out days at both static and outreach settings of supported facilities. This was done in order to reach out to as many people as possible with FP/RH services using an integrated approach. Resulting from this intervention among a suite of others by the project, the number of hours and days for FP service provision increased. Specifically, SARAI has observed the average hours of operation of clinics double from an average of 14.3 hours per week to 28.9 hours per week. The off-duty intervention accounted for 15% of all FP services provided in SARAI supported districts, reaching, on average, 50,959 FP clients (mostly LARC) per year.

The project provided the off-duty providers with transport refunds and lunch allowances per shift. Quality checks were put in place to ensure providers were providing voluntary FP within the United States Government FP statutory requirements with no set performance targets.

Figure 2: LARC Insertion Comparison in SARAI and Non- SARAI Supported Facilities



Source: Zambia DHIS2

Enhanced Family Planning Integration

Family planning and HIV integration is an important strategy for addressing the reproductive health rights and needs of women living with and at risk of HIV. According to Zambian guidelines, HIV response is to be fully integrated with SRH. However, there is no clear guidance on how this should be implemented or measured. In 2016, the SARAI Project trained 167 public sector health care providers in FP integration service delivery and oriented provincial and district health management teams on family planning integration. During service provision at different clinics (e.g. Antiretroviral &Tuberculosis, Antenatal, Voluntary Counselling and Testing, Outpatient and Inpatient Departments, etc.,), providers offered comprehensive family planning services to clients.

SFH staff disseminating FP information integrated with other health areas

Population Services International (PSI), our network partner, developed an assessment tool for the monitoring of integration of family planning into HIV services to ensure the provision of high-quality integrated services that adhere to principles of human rights, informed choice and evidence-based programming. The electronic tool contains questions divided into seven sections;

counselling, services, staffing and training, supervision, facility infrastructure, referrals, and drugs and supplies. Each section was answered by a mix of visual observation, asking facility staff, and/or examining facility records conducted in collaboration with the MOH staff and scored. A total of 40 public health facilities in Luapula province were assessed in June 2019.

Provider providing FP to client during outreach targeting adolescents

The results were as follows for each section:

1. Counselling: 37 (92.5%) facilities scored above average and 3 (7.5%) scored average;
2. Services: 30 (75%) scored above average and 10 (25%) scored average; Staffing and Training: 5 (12.5%) scored above average and 35 (87.5%) below average;
3. Supervision: 40 (100%) scored above average;
4. Infrastructure: 26 (65%) scored above average and 14 (35%) scored average;
5. Referrals: 4 (10%) scored above average, 22 (55%) scored average and 14 (35%). 95% of facilities were rural;
6. Drugs and Supplies: 22 (55%) scored above average and 18 (45%) scored average;
7. Staffing and Training posed the largest challenge due to staffing shortages.

Integration is clearly being implemented in Zambia, however, quality of the services provided varies. For quality integrated services to be achieved, there is a need to harmonize and standardize national FP/HIV quality assessment tools. With deliberate focus on quality, SRH/HIV integration can be achieved and scaled-up to support advancement toward reaching the HIV treatment cascade goals and improving family planning access.

USE OF HEALTHY FAMILY PLANNING AND REPRODUCTIVE HEALTH PRACTICES INCREASED

Youth Engagement

Confidentiality pledge (left) and Job aid(right) for Adolescent wellness days

Youth clubs & corners: Young people up to the age of 24 were selected by their peers (both in school and out of school), to be trained as Adolescent Champions, these included young mothers who shared their experiences with fellow peers before and after accessing contraception. The Adolescent Champions were the focal point for adolescents within the community, especially for the out of school youth, providing peer education and linkages to CBDs, who were able to offer FP products and referrals for additional FP/RH services. A subset of the Adolescent Champions worked with the U.S Peace Corps volunteers to form "GLOW-Girls" (Girls Leading Our World) and "ELITE-Boys" (Empowering Leaders in Teamwork and Equality) clubs, to address Social Economic barriers linked to contraception access among adolescents, the GLOW and ELITE clubs' innovation created awareness of quality adolescent health services. Annually, two training camps were conducted in the three operational provinces to develop in school adolescent champions and empowered them in entrepreneurship skills and knowledge to make informed SRH decisions. In total, SARAI supported 15 GLOW camps reaching 370 adolescent girls and 8 ELITE clubs reaching 190 adolescent boys across three provinces.

SARAI worked with youth friendly spaces (YFS) to compliment efforts that had been made to improve services for adolescents and youth by the Ministry of Health (MoH). SARAI with leadership from ChildFund

SARAI Chief of Party, Adolescents and USAID representative standing in front of the refurbished Chambishi Youth Friendly Space

was able to provide community mobilization equipment to six youth centers and refurbished three of them in the three model districts (Kalulushi, Kawambwa and Mafinga). Select members of the YFS were also trained as peer educators (90), equipping them to better respond to the needs of adolescents. SARAI further trained 255 providers in adolescent friendly health service provision against a target of 500.

Youth Messaging: Sexual and Reproductive Health (SRH) education sessions were conducted with Orphans and Vulnerable Children (OVC) below 18 years of age in SARAI supported sites including those targeting OVCs and their care givers under the USAID project ZAMFAM in select sites with funding from U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The OVC services that were provided included HIV risk assessment and FP/SRH messaging services through the CBDs in Copperbelt Province. The key SRH information shared focused on HIV/AIDS, STI, early marriages, substance abuse as well as prevention of unwanted pregnancies. One of the modes of disseminating this information was through Community Radio phone-in programmes which were a good platform in reaching out to the adolescents and men on SRH issues. The project also supported the printing and distribution of the MOH National Adolescent Health Strategy.

In collaboration with the USAID Breakthrough Action project and other partners, SARAI participated in the development of two design interventions 1) the provider confidentiality pledge (Ni Zii); and 2) Adolescent Wellness days (Ishibeni utuntu). The confidentiality pledge was a comprehensive strategy implemented in health facilities that encouraged and reminded providers to value and maintain clients' privacy and confidentiality during all interactions.

Adolescent Wellness days, on the other hand, were a dedicated monthly health and wellness day where adolescent boys and girls aged 15-19 were invited to health facilities to receive relevant voluntary services such as HIV testing as well as information on and provision of contraception. Adolescent wellness days aimed to encourage adolescents' participation in preventative health services. The two interventions were implemented in three selected SARAI health centers in Copperbelt Province on a chosen Saturday, monthly, between July 2019 and March 2020 reaching an average of 100 youth per event. A total of 249 adolescents have accessed contraception from a total of 17 adolescent wellness days.

To further improve activities targeting the youth, SARAI used PSI's program design framework known as Keystone, which incorporates the end-user from the beginning to understand barriers to contraception use among adolescents 15 – 19 years old and develop targeted evidence-based interventions. The process resulted in elaboration of a specific goal for youth programming, which was "to improve uptake of contraception by adolescents 15-19 years through strengthening their knowledge and desire to access and use quality services that are youth defined."

Project Staff, Stakeholders and Adolescents (youth designers) during the Keystone Design Workshop

Through a formative research conducted at the beginning of the process, insights were used to develop three archetypes described below:

Archetype Name	Mwaka	Tasha	Brian
Description	A girl in a rural community with limited access to financial resources. Sexually active but not using contraception because of fear of being labelled dirty and prostitute	A girl is from an affluent family with high affinity for a good life. She loves nice expensive things even though her parents provide everything she needs. She lacks information about how to use contraceptives although she has a very risky sexual life	A boy in an urban area who feels insurmountable pressure to provide even though he is given very little guidance to succeed at his assigned responsibilities
Bio Data	• Female • 16 year old • Teenage mother • Stays with grandmother • Out of school	• Female • 17-year-old • In school • Stays with the parents	• Male • 15-year-old • Lives in urban/peri-urban area • Out of school bus conductor • School dropout. • Lives with friends
Level of Knowledge on SRH	Low	Medium	Low
Level of risk	Average	High	High
Social Support	Low	Low	Very Low
Motivators/Gains	• Suffer now and enjoy later • Raising Children • Child rights	• Earns her own money • Won't fall pregnant • Fame • Experience with contraceptives	• Earns her own money • Won't fall pregnant • Fame • Experience with contraceptives
Concerns/Pains	• Financial hardships • Challenges of raising a child • Having a child at a tender age • Seeing the stepfather moving freely	• Lose respect in society • Contract STIs • Becoming a Laughing stock	• Does not feel cared for • Does not have a safe space • Does not have access to SRH services • Has few choices on contraception

The project in agreement with the youth designers and other stakeholders prioritized three new interventions based on the archetype profiles.

1. For the Mwaka archetype, the project targeted traditional counsellors (Bana chimbusas) to educate adolescent girls in the community/rural areas using skills building demonstrators who are oriented on modern FP and SRH messaging. This event was aptly named "Girls Party". SARAI also ensured a trained

Adolescent girls, project staff and USAID representative after a Girl's Party in Mansa District

provider was available on-site for counselling, voluntary service provision and/or referrals.

2. Boys club was designed for the Brian archetype and is basically a mobile big brother mentor program where adolescent boys can find a trusted resource for SRH and other life skills. SARAI also ensured a trained male provider was available on-site for counselling, condom distribution and referrals.
3. To help reduce stigma and labelling of adolescents who use contraception, branding and sensitization was developed for the third archetype, Tasha. A flyer and poster containing family planning information were developed and placed in youth hotspots, shopping malls and pharmacies. A contact number was also provided on the poster for adolescents to call a health provider and/or request SRH information, who could also refer them to the nearest health facility for FP services.

Counsellor disseminating information during Boys Club in Mansa

In urban settings, two of the interventions, girl's party and boys club were rolled out in two provinces in late 2019. Due to the project nearing closure, the need for further refinement and the wake of the COVID-19 pandemic, the intervention for Tasha was not pursued further. At least 50% of the girls participating in the girl's party event had a child or have had their first pregnancy. All three interventions showed high levels of success, with 26% of adolescents who attended events receiving voluntary SRH services, of which most were new acceptors of contraception.

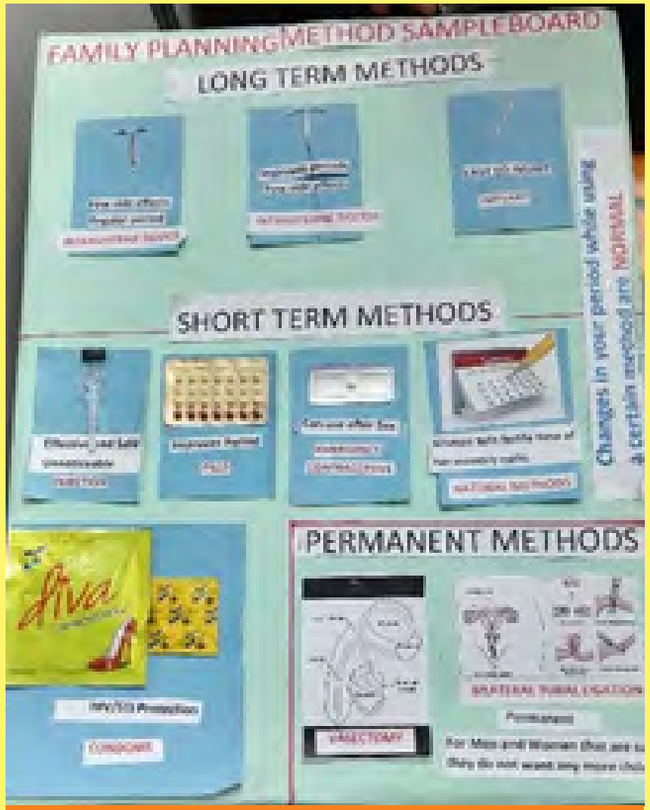
Sample Poster for Tasha Archetype

FAMILY PLANNING SERVICE DELIVERY SYSTEMS AND ACCOUNTABILITY STRENGTHENED

Strengthen Quality of FP Service Delivery

SARAI implemented quality assurance (QA) in FP to ensure that services that were being offered to clients according to national and international set standards. Measuring quality in FP was important as it helped the project have comparative data on the state of FP service provision at the beginning of the project to the end while addressing gaps along the way. Assessments were conducted jointly with identified results and gaps promptly shared with facility, district and the provincial levels to ensure action plans were documented and issues resolved. The project closely monitored the Environmental Mitigation and Monitoring Plan (EMMP) and stock availability of FP commodities in collaboration with MOH and gave feedback and trends on a quarterly basis.

At the beginning of the project, the QA service delivery standards were selected and incorporated into the M&E plan with set indicators, this was followed by the formulation of tools for data collection, analysis and reporting. The PSI QA standards were used to structure



Sample Board

the QA framework which included; technical competence, client safety, informed voluntary choice, privacy, confidentiality and patient rights, and continuity of care.

SARAI recognized the importance of having a well-established QA system at all levels of the project. Using PEPFAR QA tools, SARAI customized the assessment tools to suit the MOH facility structure and used them for the scheduled QA assessments. The project also set up the Adverse Events management, referral and reporting structures. The FP method sample boards used during health talks were re-designed for each facility and providers oriented on the "Counselling for Choice" booklet to ensure quality FP counselling was being offered. The project also supported the printing and distribution of the WHO Medical Eligibility Criteria (MEC) wheel to all facilities in the supported districts to promote FP client eligibility assessments.

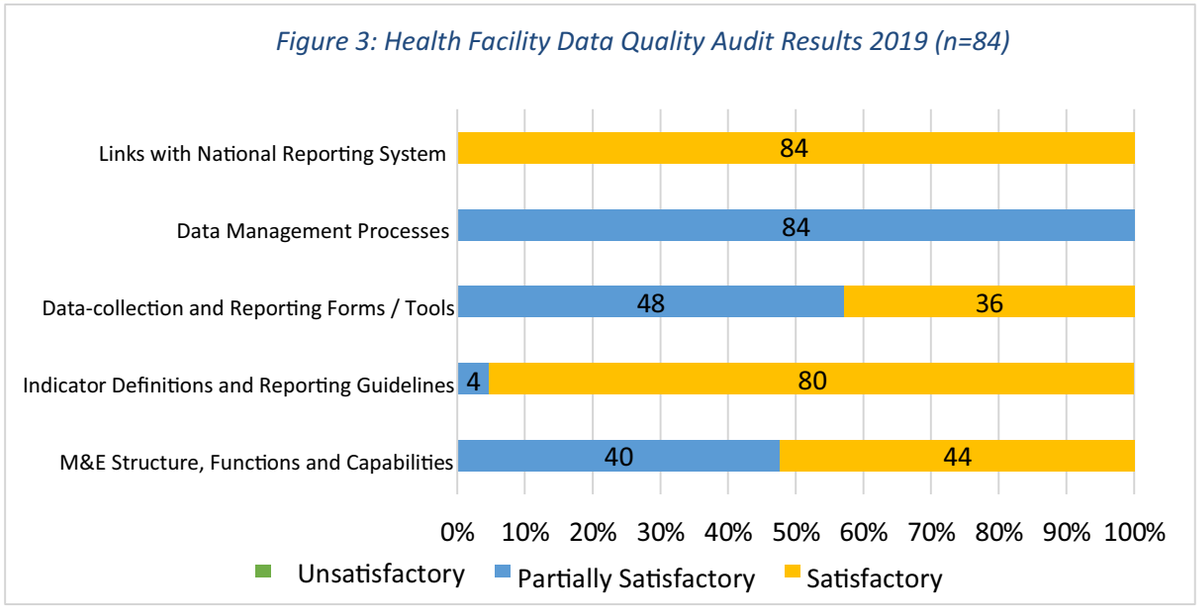
QA assessments were conducted quarterly to assess facilities against the performance indicators. In 2016, 55 out of the 88 (62%) facilities assessed were adherent to the set quality standards with the lowest score being 47%. Major gaps noted were inadequate FP protocols and guidelines; lack of Information Education Communication (IEC) materials Adverse Events (AE) reports, structured management, and reporting of AEs; inadequate counselling information; lack of uniformity in the counselling techniques across the clinics; inadequate LARC trained providers; and inadequate IP equipment. By the final QA assessment, 97% of 173 facilities were adherent to the set QA standards. In addition, a bi-annual external quality audit (EQA) was conducted by PSI. Select SARAI supported facilities scored 83%. SARAI worked jointly with MoH district mentors to ensure the sustainability of the established QA systems.

Strengthened Use of Data for Decision Making

The primary role of the Research, Monitoring and Evaluation (RM&E) unit under SARAI was to measure progress made towards the achievement of the overall goal of the project, to produce quality data to inform management and build capacity of MOH counterparts in using data for decision making. From project start-up the project worked closely with the Ministry of Health M&E structures at national, provincial and district levels to ensure that the Health Management Information Systems (HMIS) for health care facilities had strengthened capacity to generate high quality data consistently.

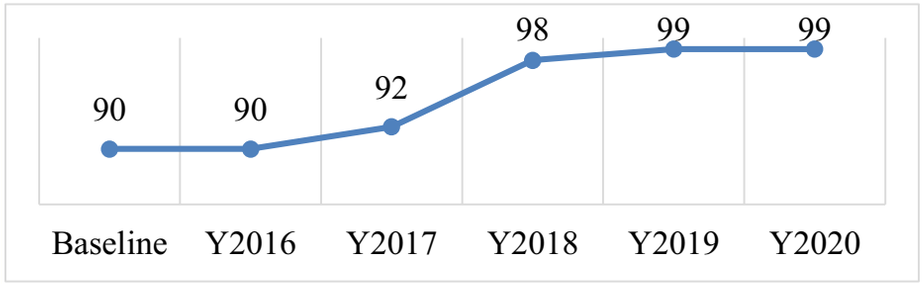
The project played a pivotal role in the development of new or refined data collection and monitoring tools such as the CBD monthly register, FP Integration registers etc., in line with MoH reporting guidelines. Regular support was provided for the Provincial and District Integrated meetings (PIMs and DIMs) where

Figure 3: Health Facility Data Quality Audit Results 2019 (n=84)



Source: Project data

Figure 4: Average Reporting Rate for SARAI Supported districts



Source: MoH DHIS2 Zambia data

performance of various reporting levels was reviewed. On a quarterly and rotational basis, the project supported district-wide data review meetings to review facility performance, share lessons and adopt best practices going forward. Figure 3 gives an analysis of data quality audits conducted in select SARAI supported facilities prior to the end of the project in 2019 which showed while most of the 84 facilities assessed have proper reporting systems linking with the national HMIS and follow reporting guidelines, facilities require more improvement with data review and analysis (as well as having permanent dedicated M&E staff. Unfortunately due to COVID-19 restrictions the last data review meetings and assessments could not take place in early 2020.

SARAI collected monthly FP service provision data in all supported facilities and produced monthly, quarterly and annual statistical reports which were essential to continuous monitoring of project activities. During data collection visits to supported health facilities, onsite mentorship and orientation in data management and processes were conducted. The data quality improvement strategy was anchored on three qualities 1.) correctness, 2.) completeness and 3.) consistency. A total of 41 data quality assessments and 43 data review meetings were conducted. Through comprehensive support, the SARAI supported facilities monthly reporting rates in DHIS2 progressively improved over the years from 90% in 2015 to 99% in 2020.

During the implementation of SARAI, two studies namely, "Assessment on Quality of Family Planning Services in Public Health Facilities in Copperbelt Province, Zambia" and "Assessment on Client satisfaction of Family Planning Services in Copperbelt and Luapula Provinces, Zambia" were conducted. The main objective was to assess the quality of family planning services as well as to assess the extent of family planning client satisfaction with the services provided in SARAI supported facilities. The results of these studies were shared with the National Family Planning Technical Working Group for consideration of recommendations.

PROJECT RESULTS

The project of four health impact indicators were for the most part achieved with some exceeding 100%. Through the methods described in previous sections, SARAI made great strides by shifting the needle for contraception in Zambia.

FIG. 6 MATERNAL DEATHS AVERTED

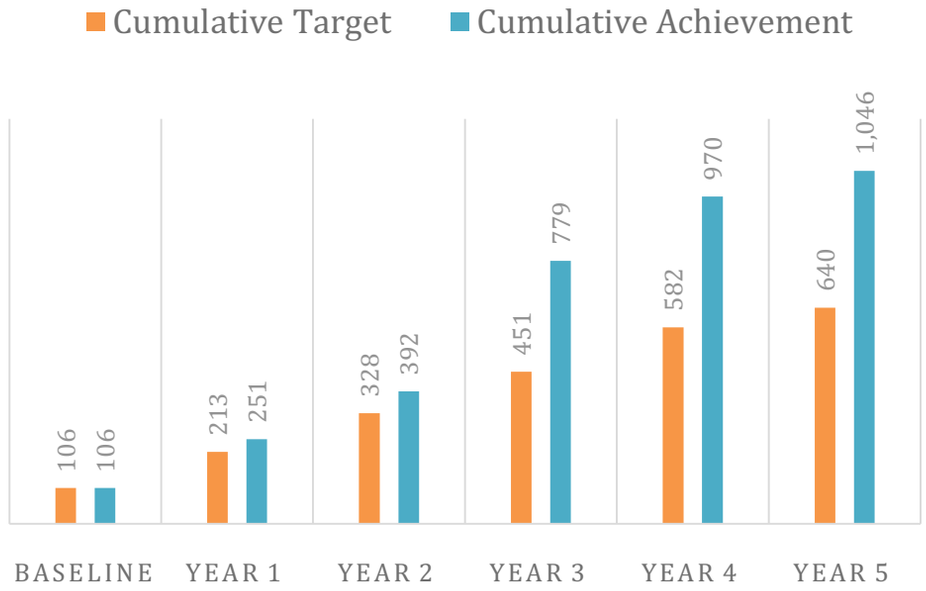
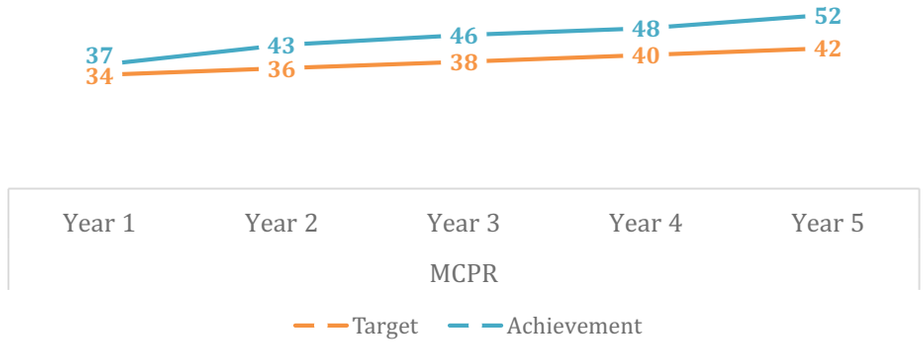
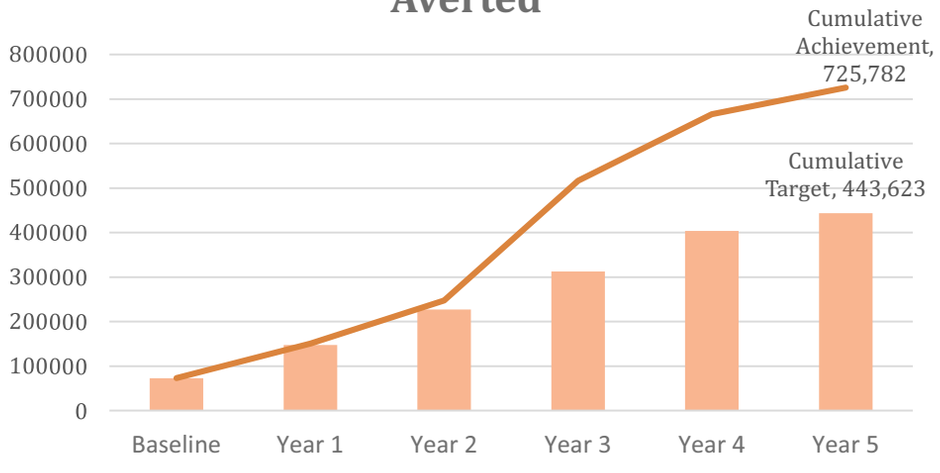


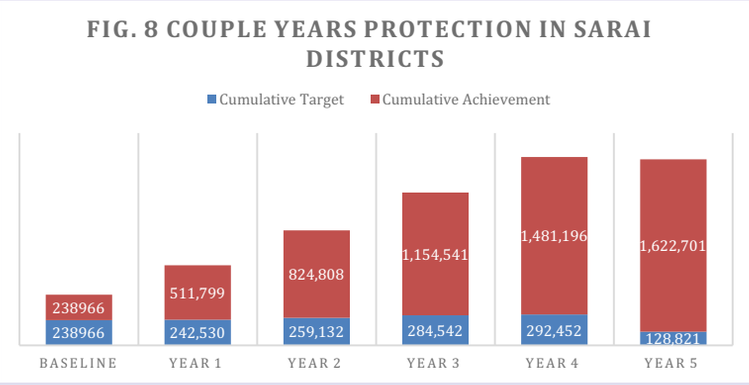
FIG. 5 MCPR ACHIEVEMENT VS TARGET



The indicator regarding CYPs remained a challenge due a larger portion of the facilities in Copperbelt province providing less than expected LARCs while their counterparts in Muchinga and Luapula with smaller number of facilities excelling. The longer the duration of the contraceptive method, the more CYPs the method will yield.

FIG. 7 Unintended Pregnancies Averted





CBDs were able to maintain extremely high retention rates and managed to reach over 20,000 clients per month and provide referrals to over 70,152 women. However, only 65% against a target of 95% were confirmed referrals due to multiple reasons including but not limited to stock out of needed commodities and misplaced referral forms. Few CBDs dropped out or were deceased during the project. Due to funding availability for additional training, not all CBDs were replaced. It is important to note that the mandate of USAID SARAI did not include provision of commodities despite measuring facility stock outs which did not meet expectations consistently although there was ongoing advocacy at the various levels for improved supply chain management. The youth program was far-reaching but due to funding challenges was not able to meet some targets such as training 500 providers in adolescent-friendly health services.

The table below shows SARAI achievements against set targets for PEPFAR and non-PEPFAR indicators:

	Baseline Oct 2014 - Sept 2015		Year 1 (Oct 2015 - Sept 2016)		Year 2 (Oct 2016 - Sept 2017)		Year 3 (Oct 2017 - Sept 2018)		Year 4 (Oct 2018 - Sept 2019)		Year 5 (Oct 2019 - Feb 2020)		Progress Towards Life of Project Targets	
Indicator	**Baseline**	**Target**	**Achieved**	**Target**	**Achieved**	**Target**	**Achieved**	**Target**	**Achieved**	**Target**	**Achieved**	**Cumulative Life of Project Target**	**Achieved Life of Project**	**% Achieved of Project Target**
Result 1.1: Improved Method Mix through Enhanced Community Based and Facility Service Delivery Models for Family Planning														
Sub-Result 1.1.1: Dedicated and off-duty provider model implemented														
# of women of reproductive age (15-49) who receive FP methods	223,653	241,380	456,362	262,480	604,185	284,542	343,269	307,605	365,249	334,869	395,102	1,654,529	1,769,065	107%
Sub-Result 1.1.2: CBD model implemented														
# of SARAI CBDs trained to provide FP information and/or services during the year	0	414	598	211	324	402	0	108	180	0	0	1,135	1,102	97%
Number of women requiring other services that are referred by CBDs (age, method)	0	4,968	4,117	15,000	7,515	36,972	29,947	54,480	21,794	22,700	6,779	134,120	70,152	52%
Proportion of women referred for other FP methods who access the services (age, method)	0%	50%	44%	85%	40%	95%	81%	90%	76%	95%	65%	95%	65%	68%

	Baseline Oct 2014 - Sept 2015		Year 1 (Oct 2015 - Sept 2016)		Year 2 (Oct 2016 - Sept 2017)		Year 3 (Oct 2017 - Sept 2018)		Year 4 (Oct 2018 - Sept 2019)		Year 5 (Oct 2019 - Feb 2020)		Progress Towards Life of Project Targets	
Indicator	**Baseline**	**Target**	**Achieved**	**Target**	**Achieved**	**Target**	**Achieved**	**Target**	**Achieved**	**Target**	**Achieved**	**Cumulative Life of Project Target**	**Achieved Life of Project**	**% Achieved of Project Target**
% of CBDs providing FP services after one year post-training	0%	97%	N/A	97%	99%	97%	98%	97%	87%	97%	94%	97%	94%	97%
Result 1.2: Enhanced FP/HIV Integration FP integration facilitated														
Sub-Result 1.2.1: FP integration facilitated														
PEPFAR FPINT_SITE: Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Sub-Result 1.2.2: Adolescents reached with age-appropriate sexual education and linked to FP/RH services														
Number of providers trained in adolescent-friendly services	0	50	66	100	129	150	0	200	60	0	0	500	255	51%
Result 2.1: Strengthen Quality of FP Services Delivery														
Sub-Result: 2.1.1 Capacity of MOH built in 15 districts.														
HRH_CURR Number of health worker full-time equivalents who are working on any HIV-related activities i.e., prevention, treatment and other HIV support and are receiving any type of support from PEPFAR	N/A	N/A	N/A	N/A	N/A	235.83	208.24	240.55	135.00	0**	0**	476.38	343	72%
HRH_STAFF Number of health worker full-time equivalents who are working on any HIV-related activities (i.e., prevention, treatment and other HIV support) at PEPFAR-supported facility sites	N/A	N/A	N/A	N/A	N/A	4.32	30.47	4.41	8.47	0**	0**	8.73	38.94	446%

	Baseline Oct 2014 - Sept 2015		Year 1 (Oct 2015 - Sept 2016)		Year 2 (Oct 2016 - Sept 2017)		Year 3 (Oct 2017 - Sept 2018)		Year 4 (Oct 2018 - Sept 2019)		Year 5 (Oct 2019 - Feb 2020)		Progress Towards Life of Project Targets	
Indicator	**Baseline**	**Target**	**Achieved**	**Target**	**Achieved**	**Target**	**Achieved**	**Target**	**Achieved**	**Target**	**Achieved**	**Cumulative Life of Project Target**	**Achieved Life of Project**	**% Achieved of Project Target**
USAID 3.1.7.1-2 Percentage of SARAI supported health facilities stocked out, by family planning product or method, on the day of the assessment during the reporting period.[1]	66%	60%	83%	40%	60%	20%	40%	20%	80%	10%	80%	10%	80%	-25%
% of FP access points adhering to quality standards for service provision	0%	20%	62%	40%	86%	50%	92%	60%	94%	70%	94%	70%	94%	134%
Sub-Result: 2.1.2 Model District-Community Family Planning Service Delivery Systems Established														
# of Model Districts established	0	9	7	3	4	3	3	2	2	0	0	17	16	94%
% of health facilities that meet the criteria for adolescent-friendliness	0%	5%	53%	10%	83%	20%	77%	30%	78%	50%	78%	50%	78%	156%
Result 2.2: Strengthened Use of Data for Decision Making														
Sub-Result 2.2.1: Data collection systems at facility level improved														
Completeness of reporting by facilities	90%	95%	90%	95%	90%	95%	92%	95%	98%	95%	99%	95%	99%	104%
Quarterly data quality assessments conducted	0	12	12	12	12	12	11	12	8	6	2	48	45	94%
Sub-Result 2.2.2: Review and analysis of data improved at district, provincial and national level														
SARAI-Supported quarterly data quality review meeting held	0	12	12	12	12	12	12	12	7	6	0	48	43	90%

[1] The cumulative percentage decrease does not apply on this indicator. The indicator is measured per year and independent of the previous performance. The percentage achieved of project target was arrived at by the following formula: [(Baseline %-Achieved %)/(Baseline %- Target %)]*100.

	Baseline Oct 2014 - Sept 2015		Year 1 (Oct 2015 - Sept 2016)		Year 2 (Oct 2016 - Sept 2017)		Year 3 (Oct 2017 - Sept 2018)		Year 4 (Oct 2018 - Sept 2019)		Year 5 (Oct 2019 - Feb 2020)		Progress Towards Life of Project Targets	
Indicator	**Baseline**	**Target**	**Achieved**	**Target**	**Achieved**	**Target**	**Achieved**	**Target**	**Achieved**	**Target**	**Achieved**	**Cumulative Life of Project Target**	**Achieved Life of Project**	**% Achieved of Project Target**
Result 3.1: Revise FP Messaging with a Focus on Youth Engagement														
Sub-Result 3.1.1: Community and individual awareness of FP developed														
# of people reached with FP messaging through community activities (sex, age)	0	50,000	105,900	160,000	512,487	190,452	1,021,560	1,111,500	1,022,361	614,792	362,991	2,126,744	3,025,299	142%
# of Adults and Adolescent Champions trained in FP by SARAI (Sex age)	0	58	576	202	0	1080	0	528	145	0	0	1,868	721	39%
PEPFAR PP_PREV: # of the priority populations (PP) reached with the standardized, evidence-based intervention(s) required that are designed to promote the adoption of HIV prevention behaviours and service uptake	0	N/A	N/A	47346	50132	37244	124920	5637	179118	N/A	N/A	90,227	354,170	393%
# of adolescents or young persons (15-24) interning with SARAI	0	18	12	18	18	18	0	18	0	6	0	78	30	38%
PEPFAR OVC_SERV: Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS	0	6,600	10,145	6,600	6,658	6,600	6,528	6,829	10,001	N/A	N/A	26,629	33,332	125%
PEPFAR OVC_HIVSTAT: Percentage of orphans and vulnerable children (<18 years old) with HIV status reported to implementing partner (including status not reported).	0	0	N/A	0	N/A	0	N/A	100%	99%	N/A	N/A	N/A	99%	99%

LESSONS LEARNT

Enhanced relationships with the PHD and DHD made it easy for the project staff to work in the public health facilities.

Clinical symposiums, regular project review meetings and on the job-training motivated staff.

Community health workers can be trained to provide quality FP services.

Peer-to-peer mentorship is more effective than external dependent TSS

Stock availability is key to service provision

Joint Supportive supervision helped clinics improve in service delivery.

On site mentorship is the best way to iron out persisting data capture errors.

Off duty model, Clinical meetings, motivated the providers to provide mixed FP services.

Use of revised FP sample boards improved FP messaging to clients.

Training and Involvement of the CBDs increased the demand of FP services as they worked as mobilisers in the community.

Integrating data verification during supervision or during off duty data collection was found to be an effective tool.

FP integration decreases client waiting time and increases ART enrollment.

RECOMMENDATIONS

Scale-up use of CBDs to provide FP services and messaging

Clinicians should also be trained in LARC and other facility support staff orientation on FP, in order to enhance integration.

MCH Coordinators conduct short trainings in provider behavioural change communication.

MCH coordinators to continue supervising the providers regularly with emphasis on adherence to code of conduct for the FP Providers.

Rotate skilled staff between facilities - Thought this was not welcome as it took skilled providers to non-focus sites…

Train more providers to replace the staff who have left the facilities.

Allocate more staff to facilities that have staffing challenges (i.e rural areas)

Train MCH coordinators to ensure that FP skilled staff are left at the facility after staff rotation.

Continue support to ensure FP methods are recorded as per MOH guideline in the Integrated FP register.

Promote timely printing and distribution of data capturing tools such as CBD monthly returns, HIA2 and Integrated FP registers

Provide continuous mentorship of all CBDs on entering FP data into the integrated registers.

Facility reporting rates in DHIS2 should be monitored on monthly basis

Conduct monthly data verification of hard and soft copies before sharing with partners and stake holders.

An integrated database should be designed in which project data can be entered.

Increase resources dedicated to targeted & evidence based youth engagement in SRH

Close follow-up of stock availability required at all levels & ensure commitments are met otherwise project to plan for buffer stock

CONCLUSION

SARAI has made significant contributions in Copperbelt, Muchinga and Luapula Provinces to increase the uptake of FP and SRH services. It is clear that much progress has been achieved throughout the project life cycle, however maximizing certain efforts will ensure that the unmet need for FP in Zambia can be narrowed. The project assisted public health facilities in provision of high-quality FP services adhering to quality standards. With the expansion of the CBD model, the project provided evidence that CBDs can consistently and safely provide FP. They have also demonstrated the significant potential CBDs have to contribute more widely to universal FP access. However, last mile distribution is an ongoing challenge hampering stock availability of a mixed method of FP commodities. The off-duty model is one particular practice that SARAI has demonstrated as one of the best ways of increasing dedicated time for provision of family planning services. Sustaining this model and expanding it to other regions will increase access to FP across the country. The project also led to significant changes in the way MoH manages FP data. Overall, data management and reporting has been strengthened leading to better use of data analytics for decision-making. Continued integration of data for the purpose of strengthening data use for decision-making is strongly recommended. The project is proud to have been part of improving the national health impact indicators such as modern contraceptive prevalence rate, unmet need for FP and maternal mortality as noted in the 2014 and 2018 ZDHS. Specifically based on the ZDHS data, in the Copperbelt province mCPR increased from 50.8% to 52.8%; in Luapula province it increased from 33.1% to 38.6% and in Muchinga province from 34.3% to 52%. The impact of SARAI is far-reaching and will carry-on for years to come.

ACKNOWLEDGEMENT

SFH Zambia extends its gratitude to the MoH, various implementing partners, health facility staff and community volunteers for their involvement and contribution to the expansion of SRH/FP services in Zambia. Lastly, we thank the U.S. Agency for International Development for their immense support for which without none of this would have been possible.

DISCLAIMER:

The author's views expressed in this report do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.