November 2014

Community Based Volunteers Skills Audit Survey Report

This report presents the findings from the Community Based Volunteers Skill Audit Survey that was carried out in 11 districts in Zambia as part of the Millennium Development Goal Acceleration Initiative.

Millennium Development Goal Initiative
Accelerating the Reduction of Maternal, Neonatal and Child Mortality

European Union

UNITED NATIONS ZAMBIA

VSO

MDGi: A Joint Programme of the Government of the Republic of Zambia – European Union – United Nations

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Table of Contents

List of Tables and Figures

Glossary

ART	Anti-Retroviral Treatment
CBD	Community Based Distributors
CBVs	Community Based Volunteers
CD	Community Development
CDA	Community Development Assistant
CHA	Community Health Assistant
CSO	Civil Society Organisation
CWAC	Community Welfare Assistant Committee
GBV	Gender Based Violence
GMP	Growth Monitor Promoter
HBC	Home Based Care
HC	Health Centre
HQ	Headquarters
ICCM	Integrated Community Case management
IYCF	Infant and Young Child Feeding
MCDMCH	Ministry of Community Development Mother and Child Health
MCH	Mother and Child Health
MDGi	Millennium Development Goal Initiative
MOH	Ministry of Health
NHC	Neighbourhood Health Committee
OVC	Orphans and Vulnerable Children
PWAS	Public Welfare Assistance Scheme
SMAG	Safe Motherhood Action Group
SW	Social Welfare
TB	Tuberculosis
TBA	Traditional Birth Attendant

Acknowledgments

We would like to acknowledge the Ministry of Community Development Mother and Child Health for making this Community Based Volunteers Skills Audit Survey possible. We sincerely thank the Provincial and District Officers from the departments of Community Development, Mother and Child Health, and Social Welfare for their cooperation during the data collection and data entry of this exercise. We would also like to thank all the Community Based Volunteers who took the time to take part in the survey. Finally we would like to thank UNICEF for their technical support, and the European Union for their financial support.

From the Research Team

Executive Summary

Following the realignment of the functions of social welfare, community development and maternal and child health under one ministry, the ministry of Community Development, Mother and Child Health (MCDMCH) – a research project was undertaken by the new ministry to assess how to enhance the coordination and utilisation of Community Based Volunteers (CBVs). The effective coordination and utilisation of CBVs is viewed by MCDMCH a key way to deliver on their mandate, and strengthen existing community structures. There were estimates of the number of CBVs, but a lot of information about these CBVs, their work, skills, and organization was unknown. The Ministry felt therefore that it was necessary to partner with VSO and DFID to support the implementation of a skills audit of CBVs working across Zambia. In addition, a qualitative research in five sample districts was undertaken to better understand the linkages between traditional community structures in the areas of community development, mother and child health, and social welfare.

The CBV Skills Audit Survey was implemented in 26 districts (2-3 per province) to represent adequately the variety of field realities in Zambia. Certain districts covered 2 districts, following the creation of new districts, bringing the total number of districts surveyed to 30.

In January 2014, UNICEF recognised the opportunity to gather baseline data about the CBVs in the districts targeted as part of the Millennium Development Goal Initiative (MDGi) using the same research project. Four of the districts targeted by MDGi were already covered by the larger MCDMCH survey. UNICEF commissioned therefore an extension of the survey to cover seven additional districts in Copperbelt and Lusaka Province. The outcome of this extension was a set of reports that will enable the micro planning of activities in the 11 districts with regard to the MDGi.

The survey was implemented in the supplementary districts following exactly the same methodology that had been used for the larger MCDMCH survey. The survey was rolled out using exclusively government staff. The VSO research team organised trainings in the provincial head towns to train 3 district officers from each selected district, 1 officer from each department (community development, mother and child health, social welfare). The district officers then selected and trained data collectors in their districts. The data collectors were chosen among government staff working closely with communities. The data collectors were posted in majority in health centres. They interviewed the CBVs based on a 4-page questionnaire which was pre-tested and reviewed by ministry representatives. The questionnaires were then given back to the district officers who were responsible for the data entry of these questionnaires into a provided data entry tool, and the submission of the data to the research team.

The data collection lasted from November 2013 to April 2014 colliding therefore with the rainy season, which has effected to some degree the completeness of the data collected. The CBVs targeted under this survey were active local Zambian persons from the communities who were delivering services under programmes in the field of community development, mother and child health, and/or social welfare to their community on a voluntary (unpaid) basis. The results of the survey have been reviewed and interpreted by district officers from the selected districts in a workshop in May2013 in order to improve the understanding of the data patterns coming out of the survey.

Key findings are highlighted below.

Understanding the Profile of Community Based Volunteers (CBVs)

CBVs are in majority women in the 11 districts targeted by MDGi, even in the rural districts. This is a different result than the larger MCDMCH survey, where most of the rural districts were male dominated. However there are differences per programme. In rural areas, Social Welfare (SW) and Community Development (CD) programmes tend to be male dominated. On the other hand, SMAG, which draws many volunteers in rural districts, is strongly female dominated with 74% of female CBVs. The factors that explain the sex disparities between rural and urban district include:

- Women have lower literacy levels. Women may not think that they can become a CBV because of their lower education level, even when women are encouraged to take part
- Culture and home duties discourage women to become CBVs in rural districts. Young women are not allowed to speak in local gatherings, and therefore cannot take part in voluntary work. Certain topics are not supposed to be spoken about by young girls (for example HIV). Pressure of home related activities (taking care of children, field cultivation) discourages women to become CBVs. Younger women are expected to support the household and their mothers and mothers-in-law
- In urban districts women are contributors to income generation at household level. They are therefore more likely to take up a CBV role, with the hope that it will materialise into a real job, or to take advantage of the incentives given to contribute to the income of the household.
- The timing of the survey, as it was carried out in the rainy season, meant that it may have missed out female CBVs who were in the fields for cultivation

➢ **Recommendation**: The over-representation of male CBVs in rural areas in programmes like Integrated Community Care Management (ICCM) or Gender Based Violence points to a re-assessment of the selection criteria for CBVs to allow more women to become a CBV. The selection criteria could include a revision of the minimum education level required to recruit CBVs and /or could include a quota based recruitment criteria.

Status of the CBV programmes

HIV, Home Base Care (HBC), and Malaria programmes are the major programmes in urban areas, while in rural areas the dominant programmes are Malaria, HIV and SMAG.

At community level, there is **clear evidence that the CBVs have already bridged the departmental boundaries between Community Development (CD), Mother and Child Health (MCH) and Social Welfare (SW);** the biggest overlap being between MCH and SW.

➢ **Recommendation**: The biggest programme overlaps reflect similarities in some subject areas, and suggest that the number of programmes being delivered in the communities should be reduced and combined to provide more integrated services of care to the communities

The workload of the CBVs in terms of number of days worked and number of clients seen per week varies a lot per programme. There are also **big discrepancies in the overall training level of the CBVs** on different programmes. These discrepancies can be explained by the nature of the programmes and the tasks expected from the CBVs.

- **Recommendation:** This calls for a systematic training of all CBVs to provide a more consistent service of care to communities.

The **level of Government/Civil Society Organisations (CSO) partnership varies a lot per programme**. Social Cash Transfer, PWAS, ICCM/Child Health, Malaria, SMAG and Food Security are programmes dominated by CBVs working under the government. Whilst OVC, GBV, and HBC programmes are dominated by CBVs working for CSOs.

CBV engagement in a programme differs greatly according to whether a programme is implemented by the Government or by a CSO. In a given programme, CBVs working for CSOs tend to work more days and see more clients per week than CBVs working under the government. However, Government CBVs are also tied to the government schedule of activities, which may explain their lower level of days worked per week. CBVs are more likely to be trained if they work for a CSO than if they work under the government.

Supervision and CBV structures

The overlap of programmes (ie CBVs working for several programmes simultaneously) is replicated into the overlaps of committees which the CBVs belong and report to. CBVs are likely to belong to several committees simultaneously.

Analysis of the biggest committee overlaps suggests opportunities for **merging some of the health related committees**. CBVs involved in the NHC are over 50% likely to also belong to the SMAG, the AIDS coordinating committee, the CATF, or the water sanitation committee.

The largest committee is the NHC, both in urban and rural districts. The SMAG is also an important group for getting in contact with the CBVs in rural communities, as 17% of CBVs in rural areas also belong to the SMAG.

Regardless which committee or organisation they report to, over 95% of CBVs state that they have a supervisor in these organisations, and that they received guidance from these supervisors.

- **Recommendation**: A reduction in the number of the committees would help to simplify the supervision of CBVs.

Current State of CBV training

A large proportion of CBVs are trained in health specific training. Factors that explain the dominance of health related trainings include: the historical HIV epidemic; and that health has had more partners for capacity building in clinical areas such as malaria, TB, HIV etc.

The biggest training overlaps are between HIV counselling, and HIV testing, ART adherence, HBC, Peer Education, Women and Girls Rights, and GBV. New born care and SMAG also overlap.

There are big differences per training area in terms of how recently the training occurred, the length of the training, and updates of the training. Some training areas seem to have been neglected.

Not only are there big differences from one training area to another, but within particular training areas there are also differences depending on who delivered the trainings.

- **Recommendation**: This calls for a harmonisation of training curriculums, in order to maximise the impact of the CBVs towards their communities. Combining training areas into multi-facetted training curriculums would also help the CBVs provide better integrated services – community development, mother and child health, and social welfare – to the communities.

CBV Incentives and Motivation

A small proportion of CBVs receive money (usually less than K30 per day) or goods from their organisation or their clients in exchange for their services. Over 25% state that their incentives have decrease or stopped completely over time. The disparities in the incentives received amongst CBVs causes problems in terms of the sustainability of the programmes. CBVs are likely to drop-out of programmes when incentive levels change.

The drop-out rates vary greatly per programme. The programmes that seem to have the most drop outs are Nutrition (56% drop-outs), Literacy (40%), Food security (40%), GBV (35%) and ICCM (42%). In contrast SMAG and OVC have the lowest drop-out rates, especially in rural districts with respectively 9% of 17% drop-out rates, which is a good sign for the continuity of the service delivery in the communities. The drop-out rates vary from the larger MCDMCH survey. In the MDGi districts, the proportion of drop-outs in rural districts is higher than in urban districts, especially in the programmes of ICCM and HIV counselling and testing. In the MCDMCH survey where there are generally more drop-outs in urban districts than in rural districts.

- **Recommendation**: Guidelines should be introduced to harmonise the incentive levels and clearly set out to both CSOs and Government how to fairly and equally reward CBVs for their work; and therefore help to prevent competition between programmes.

INTRODUCTION

The Ministry of Community Development Mother and Child Health (MCDMCH) relies on Community Based Volunteers (CBVs), who work in communities in the areas of community development, mother and child health, and social welfare, working directly under the ministry or with local, national and international Civil Society Organisations (CSOs). There are estimates of the number and skills of CBVs (estimated at around 100,000 CBVs in Zambia), but there is limited systematic information about their activities, skills, and organisation. Therefore, MCDMCH commissioned a survey with DFID funding in order to gather quantitative and qualitative information on the CBVs, particularly in relation to their skill set, activities, and organisation.

The objective of the survey was to gather a more detailed understanding of the state of the CBV skill typology and level as well as involvement in various programmes in order to strengthen existing community structures and to improve coordination and effective utilisation of CBVs for better service promotion and delivery. The final objective of the research project was to develop a draft national strategy identifying opportunities and guidelines for greater convergence and integration across MCDMCH departments (i.e. Community Development, Mother & Child Health, and Social Welfare) including through CBVs. The draft national strategy is planned to be delivered to the Ministry in July 2014.

In January 2014, as part of the baseline assessments for the Millennium Development Goal Initiative (MDGi), UNICEF recognised the opportunity to source baseline data and information about Community Baseline Volunteers. Out of total 11 MDGi target districts, 4 were already included in the study design commissioned by MCDMCH with DFID funding. Therefore MCDMCH, with UNICEF technical support and European Union funding, commissioned an extension of the survey in order to cover the remaining seven MDGi target districts hence reaching full inclusion of MDGi target districts in the study design. Two supplementary Trainings of Trainers (TOTs) were conducted in January 2014 and the survey was rolled out in supplementary districts from February 2014 to May 2014. The outcome of this extension was a set of reports that will enable the micro planning of activities in all 11 target districts with regard to the MDGi.

METHODOLOGY

Target Group Definition

The population targeted by this survey are the Community Based Volunteers (CBVs).

For the purpose of this survey, CBVs are defined as **active** local Zambian persons who deliver services within their communities in the fields of community development, mother and child health, and/or social welfare on voluntary basis i.e. without formal financial remuneration for the services that they deliver. CBVs may work directly under one of the departments of MCDMCH and/or through a Civil Society Organization..

A CBV was considered active if s/he had seen at least one client in the 12 months preceding the survey. The rationale for this definition takes into consideration variations in CBW activity continuity/ frequency, due to seasonality (activity is most frequent during the dry season) and/or funds flow (activity may slow down/interrupt due to program funding).

CBVs working within the following programmes were interviewed.

Table 1: Programmes included in the survey

Programmes	Summary of activities
Community Development	
Food Security Pack	In the Food Security Pack programme (FSP) the beneficiaries are given farming inputs such as seeds and fertiliser to do farming during 2 years. This programme is meant for vulnerable but viable people who have a field and are able to work in the field, but have no money to buy farming input. The CBVs working for the FSP committee identify the people who are susceptible of being helped through the programme, links them to the CDA or CDO, supervises them and ensures they pay back the surplus
Literacy Programme	CBVs working in this program teach illiterate people are taught how to read, write and do mathematics. In addition, they also teach some skills needed for income generating activities
Gender Based Violence	CBVs working in this program deals mostly with victim Support and Assistance with Police proceedings
Mother and Child Health	
Nutrition	Donation of food by the ministry through CBVs to malnourished adults and children, and lessons on nutrition are given to adults including mothers and caregivers.
Malaria control	Voluntary malaria control agents sensitize the community about malaria, and how to avoid it. Occasionally, there is distribution of and teaching about mosquito nets
HIV/AIDS, and TB	Control, prevention, treatment and care of HIV, AIDS, and TB. The CBVs sensitize the community about early testing, symptoms, how to avoid getting infected, stigmatisation and visit HIV positive people to encourage them to take their drugs as prescribed. Some groups of CBVs also sensitise about HIV prevention from mother to child (PMTCT)
Home Based Care	Delivery of Home Based Care services for bedridden HIV and AIDS or TB patients, and their caregivers are counselled how to provide better care
Safe Motherhood	Sensitization of pregnant women (and their husbands) on issues concerning pregnancy and delivery. The programme is done both in the health facilities and in the communities by the SMAG, which encourages pregnant women to deliver in the health facilities, to go for antenatal care (ANC) and post natal care, and to the under five clinics. Some SMAG groups also teach about PMTCT and/or family planning
Child health / ICCM /IMNCI	Promotion, prevention, and treatment of common Childhood Illnesses as per national ICCM and IMNCI protocols
Water and sanitation	Sensitization on safe water and sanitation
Orphans and Vulnerable Children	Assistance, counselling, and monitoring of children who are abused, orphaned, or vulnerable

Social Welfare	
Public Welfare Assistance Scheme / Social Protection Fund	In the Public Welfare Assistance Scheme (PWAS) the government gives food to people who cannot provide for themselves. The main beneficiaries are disabled people, elderly people, widows and extremely poor families who look after several orphans. The beneficiaries are identified by a community committee called the Community Welfare Assistant Committee (CWAC), which refers beneficiaries to the Social Welfare Officer (SWO). The SWO ensures that the potential beneficiaries meet the requirements as prescribed in the ministry's guidelines and that the beneficiaries will be assisted with food supplies.
Social Cash Transfer	The Social Cash Transfer was meant for destitute and incapacitated households, especially elderly people who are 65 years and above, who have no means of income. The beneficiaries are identified by the CWAC, and receive the money (about ZKR 80 per month) from the government through the SWO. Part of this money is donated to the government by donors. During the time of the research the Social Cash Transfer programme was expanded (a scale up of about 700%) by the government, with donor money, predominantly from DFID , and a consortium consisting of UNICEF, Finland, and Irish Aid.

Survey sites location

All eleven (11) MDGi target districts were included in the survey, of which four were covered in the initial survey design commissioned by MCDMCH with DFID funding, and seven were added later through an extension of the survey commissioned by MCDMCH with UNICEF technical support and European Union funding. The districts included in the survey were:

Table 2: Districts included in the survey

Province	District		Classification
Copperbelt	1.	Chingola	Urban
	2.	Kitwe	Urban
	3.	Luanshya	Urban
	4.	Masaiti	Rural
	5.	Mufulira	Urban
	6.	Ndola	Urban
Lusaka	7.	Chilanga	Urban
	8.	Chongwe	Rural
	9.	Lusaka	Urban
	10.	Kafue	Urban
	11.	Rufunsa	Rural

Survey Implementation

Staffing

The survey was implemented and supervised by MCDMCH line departments' staff at province and district levels, selected from the following cadres:

- Community Development (CD): Assistant Community Development Officer
- Mother and Child Health (MCH): Information Health Officer or Environmental Health Officers
- Social Welfare (SW): Assistant Social Welfare Officer

In total, three officers (one from each of MCDMCH line department) per district were selected and trained to implement the survey in their district. One Training of Trainers (TOT) per province was conducted and included the following modules: survey purpose and objectives, methodology, and data collection tools.

The district officers Terms of Reference included the following roles and responsibilities:

1. Selection and training of data collectors, as per shared guidelines
2. Supervision of data collection including monitoring data collectors, collecting and assessing completed questionnaires
3. Data entry, including s transferring data from paper-based questionnaires into electronic format and submitting data to HQs at the Ministry of Community Development, Mother & Child Health).

Data collection was conducted by MCDMCH line departments' staff at local level, selected from the following cadres:

- Community development assistant (CDA)
- Community Health Assistant (CHA)
- Health facility staff

In locations where sufficient numbers of data collectors could not be identified, alternative cadres were selected based on the following criteria: government staff; grade 12 education; good knowledge of community structures; good English and local language capacities.

Data collectors were trained by trainers in a 4-5 hour training session at district level. In urban districts, data collectors were trained in one of up to three training centres. In rural districts, data collectors were trained at a central and easily accessible venue of the Boma. In more remote areas, trainers travelled to train data collectors on site. In total, 395 data collectors were selected and trained in 11 survey districts.

Data Collection

Data collection sites

Data collection was located at health facility sites in 11 survey districts.

Health facilities were selected as data collection sites as CBVs are attached to reference health facilities for activity planning, reporting, and supervision. Data collectors interviewed CBVs at their reference health facilities.

Whilst this approach was cost and time-effective to capture as many CBVs as possible, it had weaknesses whereby CBVs who did not report to the health centre during the data collection period (especially those located farer from health centres) were missed out by the survey.

Mobility of the data collectors

Survey data collectors were static, and posted at assigned health facilities. This allowed them to be always present at the point of data collection for interviews with CBVs, and to be able to continue their normal work activities.

Number of data collectors per health facility

The number of data collectors was proportional to the number of health facilities in each district and district typology, to take into account variations across districts.

For rural districts, one data collector was posted per health facility. However, up to two data collectors were posted per health facility in some rural districts (Chongwe and Rufunsa) with few health facilities and in urban districts with high population density, to ease data collection.

For urban districts, between one and three data collectors were posted per health facility proportionally to health facility type/level, number of CBVs attached to the health facility, and catchment population size.

Data collection tools

Data was collected using a standardized four-page paper-based questionnaire, with a majority of closed questions and a few open-ended questions. The questionnaire was tested in two different sites in Chirundu (a rural district) and Mandevu compound in Lusaka (an urban district), and underwent a number of reviews with ministry staff. Adjustments were made after each test or review to refine the content of the questionnaire.

The questionnaires were written in English, and were translated into local language by the data collectors during data collectors. The estimated time for questionnaire administration was about 40-50 minutes.

Responses captured in the paper-based questionnaire were transferred by the district officers into a standard data entry tool in Microsoft Excel and submitted to HQs.

Survey monitoring

Monitoring was conducted at three levels:

1. District monitoring: Each of the three district supervisors monitored the data collectors that s/he had trained.
2. Provincial Monitoring: Each of the three provincial officers who attended the Training of Trainers were instructed to monitor the district supervisors. Their responsibilities included: 1) to attend one training session for data collectors; 2) visit a sample of health facilities and supervise data collection quality
3. HQ Monitoring: The research team (VSO research staff) monitored the survey exclusively remotely through phone calls and emails to the provincial officers and to the district officers at regular intervals to follow up on activity progress status.

Data Analysis

Once sent to HQ, all the Excel files from survey districts were aggregated, consolidated, and any duplicates removed to ensure that each volunteer was captured and counted only once. The analysis was conducted using SAS and Excel. Data was cleaned and transferred into a suitable analysis format in SAS. Text data were also coded to facilitate the analysis.

Survey implementation timeline

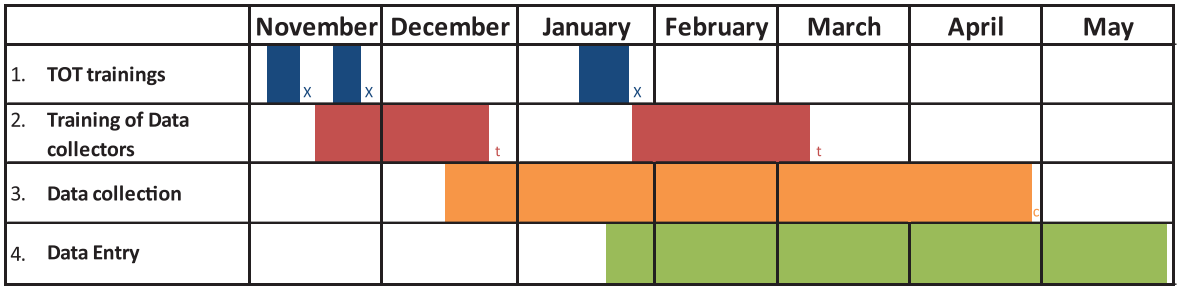
Survey activities were implemented between January 2014- May 2014.Data was collected during the rainy season, which was a challenge (see Data Disclaimer section for further details).

The cut-off date for data entry was 31st May 2014, at which point all data had been received from the survey districts.

Table 3: Summary work plan

Activities	Dates
Tot Training	· First 4 districts (Lusaka, Masaiti, Ndola, Kitwe): November 2014 · Supplementary 7 districts (Chingola, Chilanga, Chongwe, Mufulira, Luanshya, Kafue, Rufunsa): January 2014
Training of Data Collectors	· First 4 districts (Lusaka, Masaiti, Ndola, Kitwe): From November 2014 to December 2014 · Supplementary 7 districts (Chingola, Chilanga, Chongwe, Mufulira, Luanshya, Kafue, Rufunsa): From January 2014 to February 2014
Data Collection	From December 2013 to April 2014
Data Entry	From January 2014 to May 2014

PLAN



Data Disclaimer

The following described field constraints affected data collection.

- The survey was conducted in the rainy season. This hindered data collection in two ways. First, some of the CBVs were occupied in field cultivation. Women were especially likely to be working in the fields at this time of year, hence female CBVs may have been under-represented in the survey. Secondly, the rain made certain roads impassable, and led some districts to exclude certain health facilities from the survey as they could not be reached. It is difficult to estimate the number and specific distribution of CBVs who may have been excluded from the survey due to these reasons.
- The survey was rolled out using static data collectors stationed at health facilities, and relied on the CBVs coming to the health facilities to be interviewed. This approach was flexible and made good use of existing structures and reporting mechanisms at health facilities, but created a bias in the survey whereby CBVs with easier access to health facilities were more likely to be interviewed compared to those with access constraints and may have been excluded from data collection.
- Data collectors were selected from health facility staff, who worked in the survey in addition to their regular duties. The additional workload was significant and some data collectors could not interview the expected number of CBVs. The data collectors did not received specific targets, as the number of CBVs around their health facilities was unknown at the beginning of the survey, and were instructed to interview all CBVs known to them.
- The number of CBVs working under CSOs captured by the survey varied a lot from district to district. The differences can be explained by the varying levels of CSO presence from district to district, and the level of sensitisation of the CSOs that the districts officers did.

FINDINGS

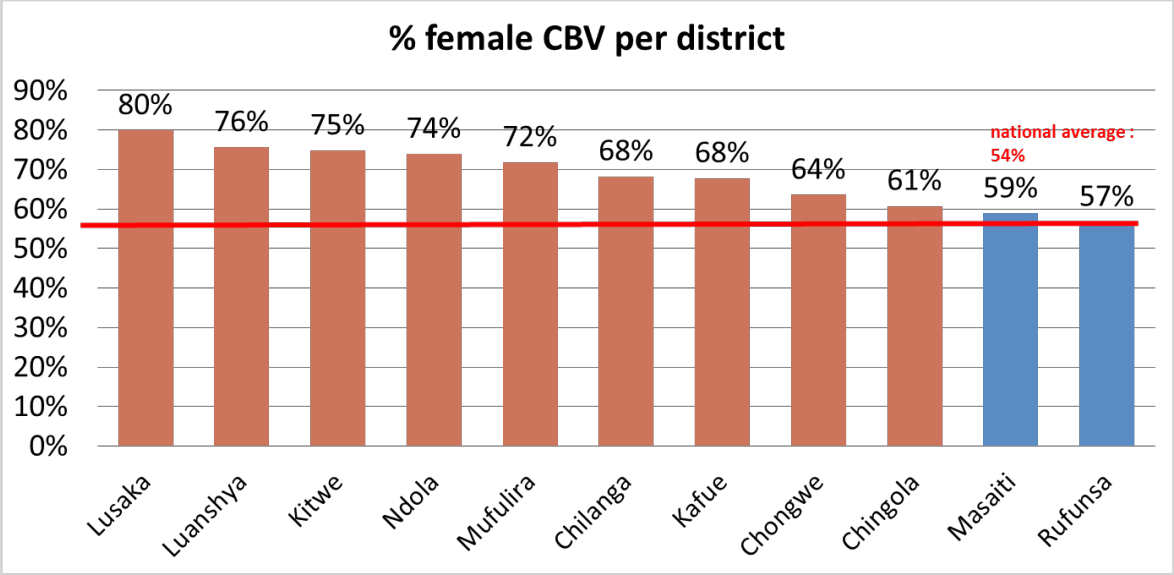
CBV profile

Gender

The majority of CBVs in MDGi Districts are female, in urban districts as well as in rural districts.

This finding differs from national trends as showed in the nation-wide survey, where the majority of CBVs in rural districts tend to be male. Even if this national trend does not appear in the three MDGi districts with predominantly rural population (Masaiti, Rufunsa and Chongwe), they do have overall fewer female CBVs than urban districts. Only 60% CBVs in these districts are female, compared to 71% in urban districts. CBV gender distribution seems to be directly proportional to the degree of urbanization, with female CBVs being more prevalent in densely populated and urbanized districts as shown in Figure 2. This finding points to distinctive demographic and socio-economic characteristics in MDGi districts, which are predominantly urban/peri-urban.

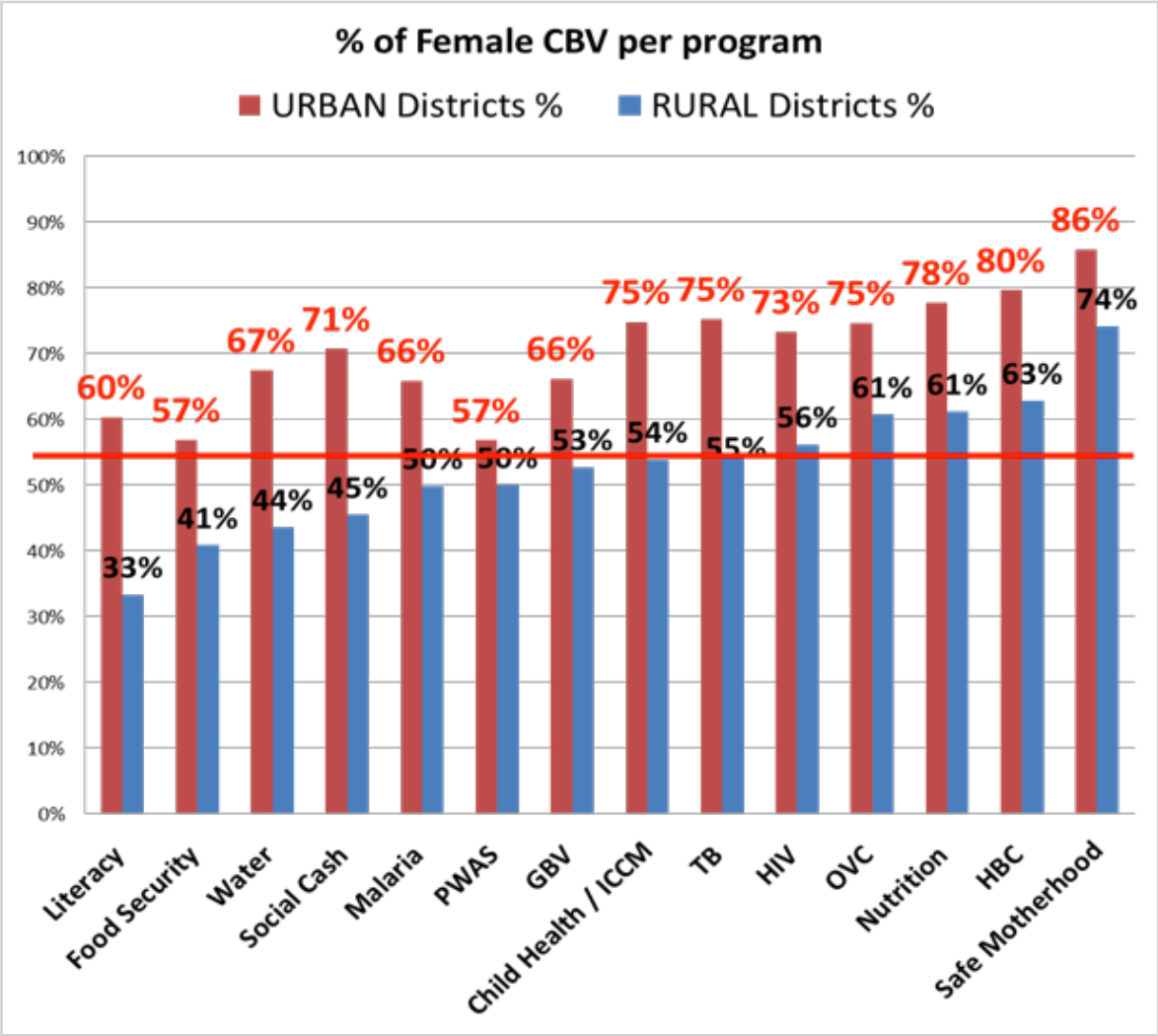
Figure 1: Proportion of female CBVs per district



However, female CBVs prevalence is not homogeneous across MCDMCH programs, especially in rural districts, as shown in Figure 3. The gender repartition per programme shows an under-representation of female CBVs in rural districts in certain programmes such as Literacy, Food security, Water and Sanitation and Social Cash transfer.

This finding is consistent with national trends as showed in the nation-wide survey, where certain programs in rural districts are dominated by male CBVs, while others (like SMAG) are dominated by female CBVs. Overall, Community Development and Social Welfare programmes have the lowest prevalence of female CBVs. Within Mother & Child Health programs, Safe Motherhood Action Groups have the highest prevalence of female CBVs, though 26% of them are men in rural districts, and 14% in urban districts.

Figure 2: Proportion of female CBVs per programme – comparison Rural vs. Urban districts



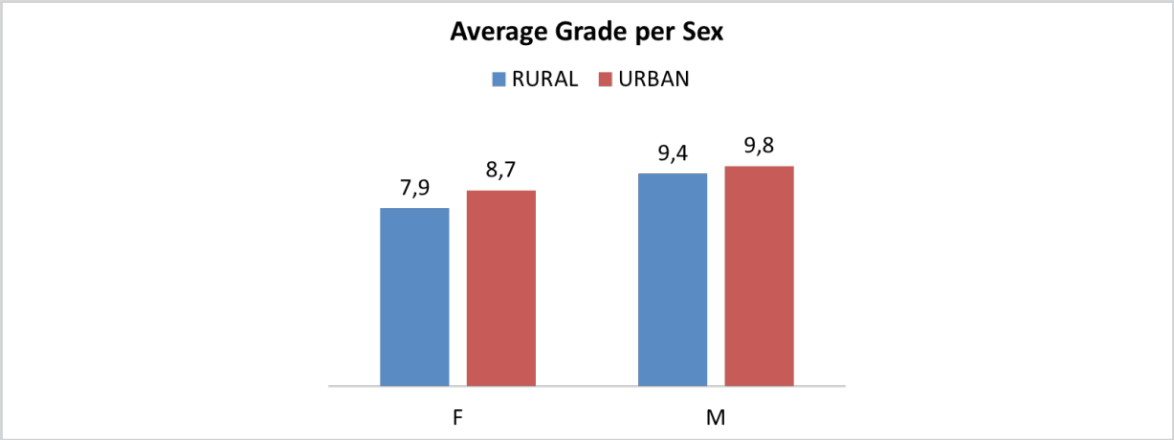
Factors that explain the gender disparities between rural and urban districts include:

- National literacy rates are lower in women, in both urban and rural settings. In rural districts, the median number of years of schooling completed is 7.9 and 9.4 in respectively, female and male CBVs (see Figure 3)
- Traditional Cultural Values: Culture and home duties discourage women to become CBVs in rural districts. Women are expected to take care of the household, leaving thus little time for volunteering
- Opportunity costs: In urban districts, women are employed and contribute into the household income. They are therefore more likely to take up the role of Community Based Volunteer owing to the hope that it may lead to a remunerated job, or give access incentives. Although women in rural districts also contribute to the income of the household, cultural factors are stronger in rural areas and may take precedence to discourage women to volunteer
- Some programmes like SMAG are tailored for female CBVs
- An unspecified number of female CBVs may have been unintentionally missed out in the survey, as data was collected during the rainy season when women are typically in the fields for cultivation.

Literacy

Generally, men are more exposed to education than women both in rural and urban districts. In rural districts, the average grade of female CBVs is 7,9 whereas the average grade of the male colleagues is 9,4.

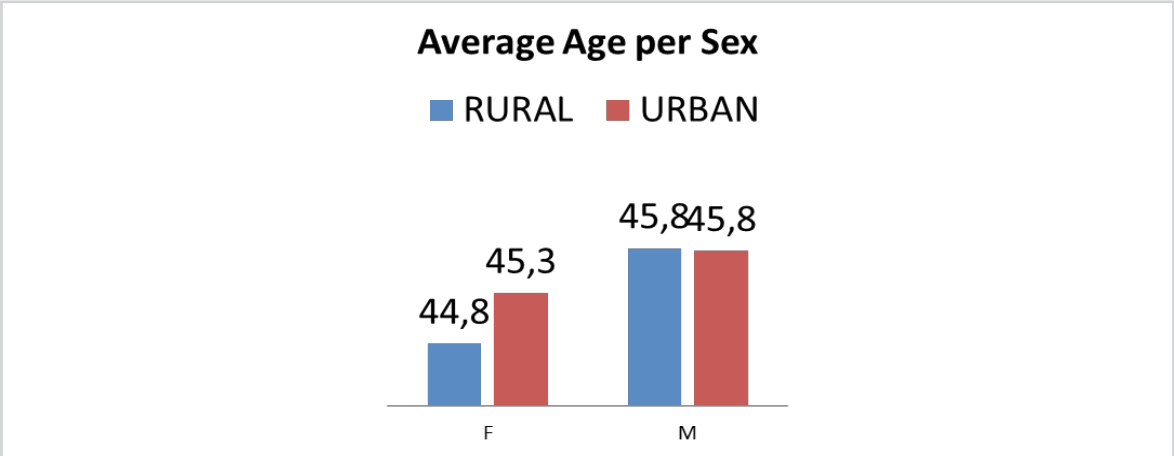
Figure 3 : Median number of years of schooling completed - comparison by gender and Rural vs. Urban districts



Age

Women tend to be younger than men in both rural and urban districts. This is a diversion from the larger MCDMCH survey where women were older than men in rural districts as they are freed from home duties.

Figure 4: Average Age per Sex. Comparison Rural vs. Urban districts



KEY MESSAGE:

CBVs vary between rural and urban areas in terms of gender, age, and literacy levels. Higher prevalence of male CBVs in rural areas indicates the opportunity to assess and possibly revise CBV selection criteria for greater enrolment of female CBVs.

Mobility

Bicycles seem to be under-used as a main means of transportation.

Walking is the main means of transportation with bicycles coming far behind. Indeed, 82% of CBVs in urban districts, and 71% of CBVs in rural districts place it as their main means of transportation. Bicycles are more used in rural areas than in urban areas (23% in rural areas versus 8% in urban areas), but it seems that bicycles given as incentive are not always used as the primary means of transportation. Forty-five percent (45%) of CBVs, who state that they received a bicycle as an incentive for volunteering, do not mention it as their main means of transportation. In urban districts, this figure goes up to 71%.

In most cases, CBVs directly identify clients.

65% of CBVs across all MCDMCH programmes identify clients directly through household mapping and registration.. Moreover, CBVs working with Health and Nutrition related programmes (especially TB, SMAG, Nutrition, and Malaria Control) also use information provided by their reference health facilities as an additional method of client identification. For instance, 72% CBVs working with the TB program, identify clients through information provided by their reference health facilities s while respectively 37% and 45% CBVs working with the HIV prevention and GBV programmes identify clients through referral.

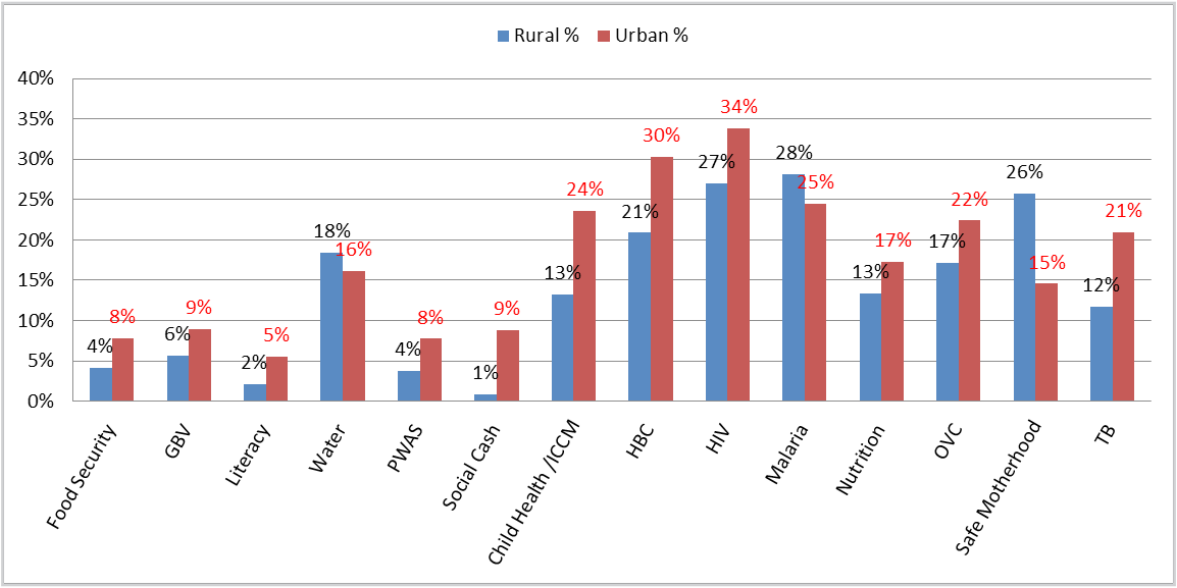
Programmes

Programme Repartition

In urban districts, CBVs are mostly associated with the following programmes: HIV/AIDS prevention, Home-Based Care, Malaria, Integrated Community Case Management, and Orphans & Vulnerable Children; while in rural districts, CBVs are mostly associated with the following programmes: Malaria, HIV/AIDS related programmes, Safe Motherhood Action Groups, and Home-Based Care.

These findings are reflected in Figure 5, which displays CBV distribution by programme in rural and urban districts.

Figure 5: CBV distribution by programme – comparison Rural vs. Urban



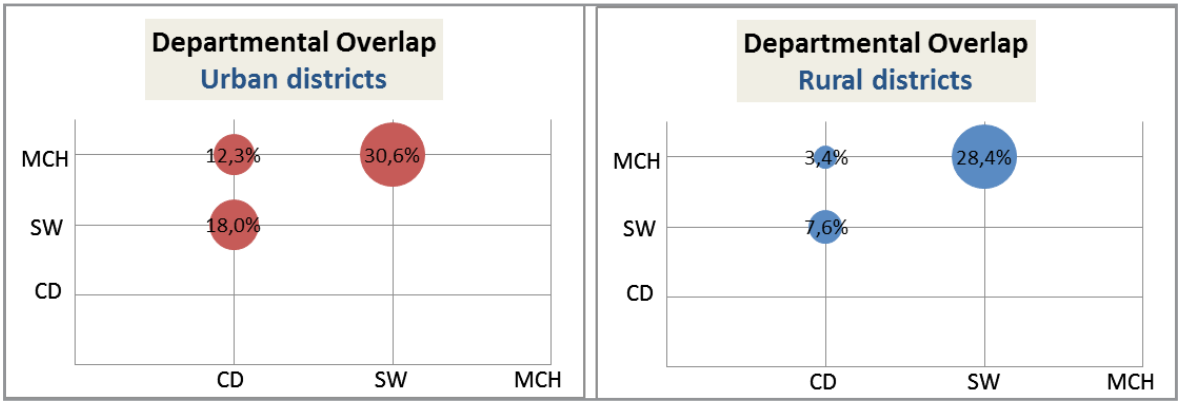
This finding is in line with the nation-wide CBV survey. A slight variation is observed regarding SMAGs, as nation-wide 30% CBVs are associated with SMAGs in rural districts compared to 26% in predominantly rural MDGi Districts (Chongwe, Rufunsa, and Masaiti).

Programme Overlap

CBVs are associated with multiple programs across MCDMCH departments.

As reflected in Figure 6, respectively 60 and 40% CBVs in urban and rural districts are associated with multiple programs across MCDMCH Departments. The largest overlap is observed between Mother & Child Health and Social Welfare Departments, which alone account for about 30% overlap across MCDMCH Departments. These findings are consistent with the nation-wide CBV survey.

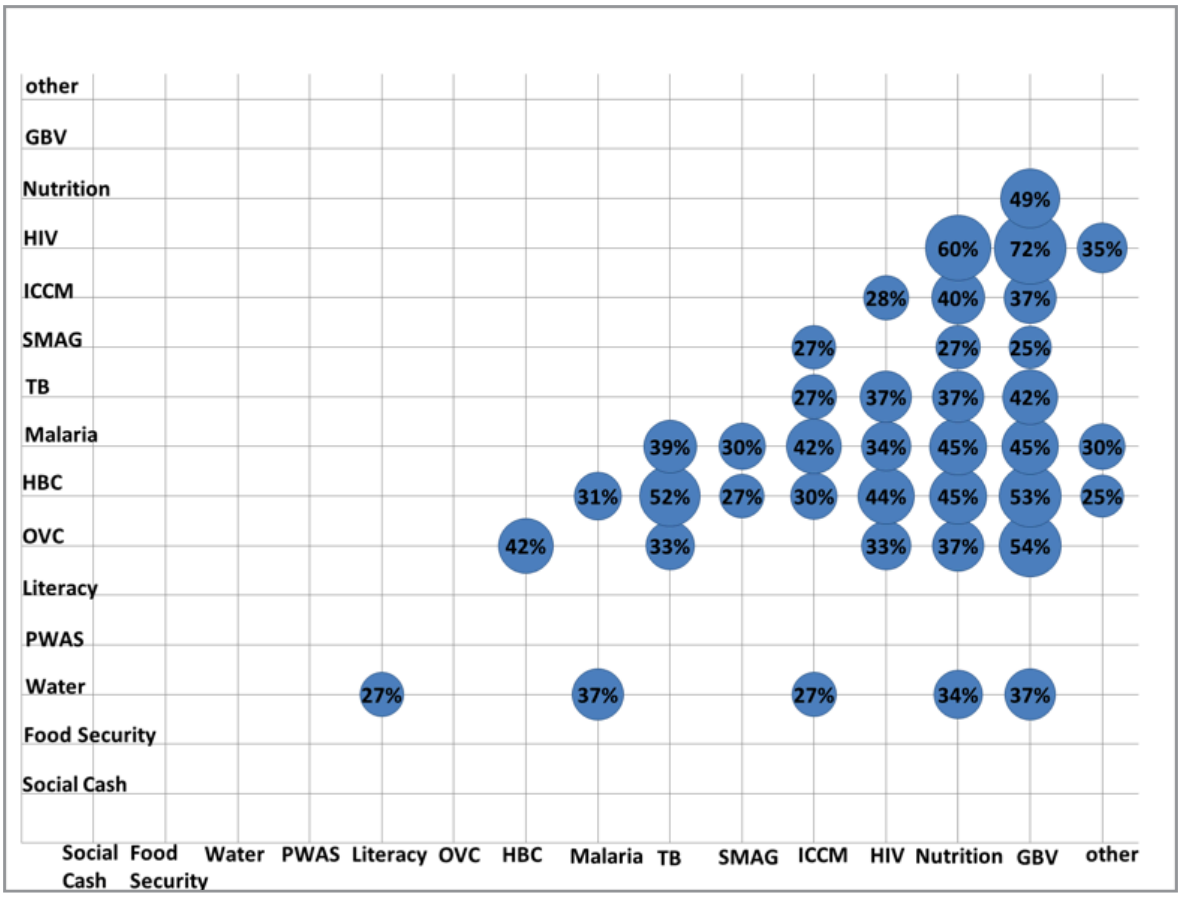
Figure 6: Departmental overlaps



Large overlaps across MCDMCH departments and programs suggest significant opportunities for activity/service convergence and integration.

Of the CBVs working for the HIV prevention programme, 60% also volunteer under the Nutrition programme, and 72% under the GBV programme. Fifty-two percent (52%) of TB CBVs are also volunteers for the HBC programme. Similarly, 54% of the CBVs working under the Orphan and Vulnerable Children (OVC) programme also work for the GBV programme. The highlighted (red) bubbles in Figure 7 show the biggest overlaps.

Figure 7: Overlaps by MCDMCH Programme



Note: There are overlaps between all of the programmes, but for better readability only overlaps over 25% are shown in the graph.

The following table highlight the overlaps for specific programmes of interest for MDGi activities.

Table 4: Overlaps for MCH programmes

	Malaria control Program	Safe Motherhood Action Program (SMAG)	Child Health / ICCM	HIV	Nutrition
Malaria control	100,0%				
Safe Motherhood	30,1%	100,0%			
Child Health / ICCM	42,1%	26,7%	100,0%		
HIV	33,9%	19,7%	27,8%	100,0%	
Nutrition	45,3%	27,1%	39,9%	60,1%	100,0%

KEY MESSAGE:
Large programme overlaps can be observed through a number of CBVs working simultaneously for different programmes. This suggests that the number of programmes run in the communities share similarities, and could be reduced and/or combined to provide more integrated services of care to the communities.

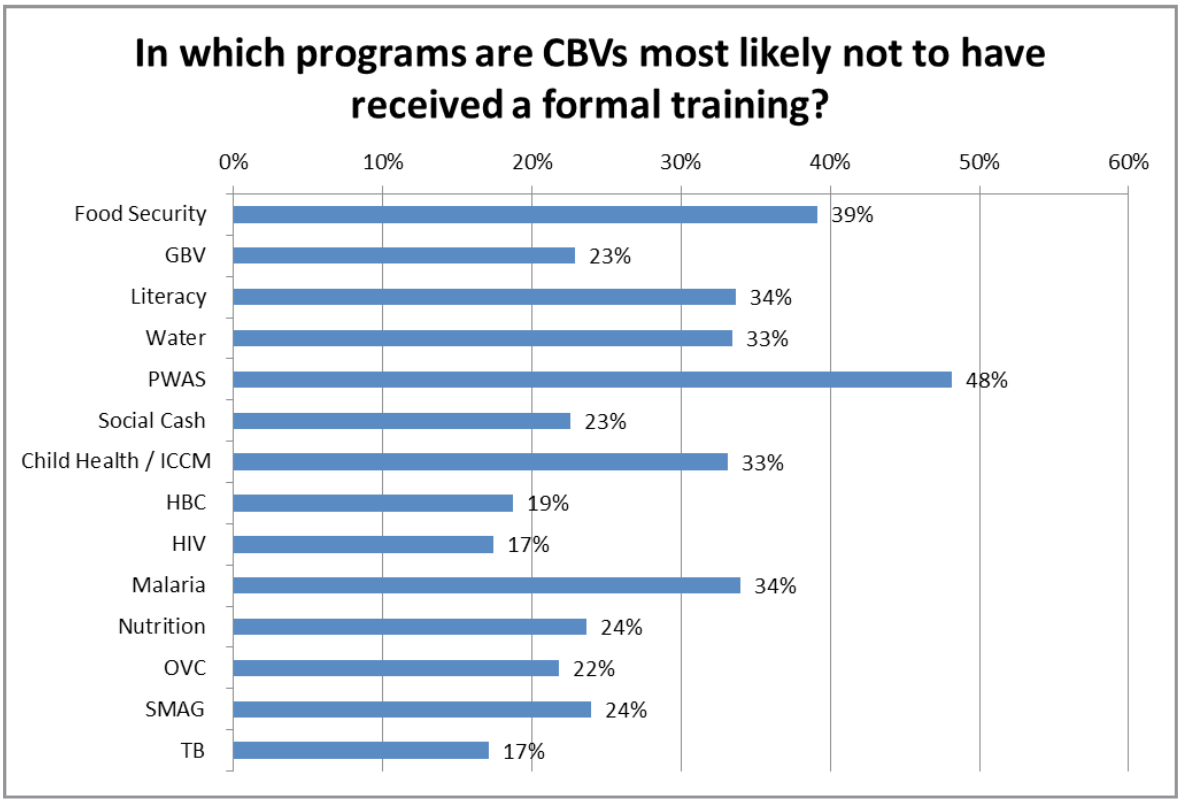
Training Level per Programme

There are big discrepancies in the overall training level of the CBVs on different programmes.

Some programmes have a very high percentage of CBVs who have NOT received formal training before starting to work on these programmes, as reflected in the Figure 8. CBVs in PWAS and Food Security have the highest proportions of untrained CBVs, with respectively 48% and 39% of untrained CBVs. In the Health sector, a third of CBVs in Malaria, and Child health/ICCM are untrained. Similarly, a third of CBVs in Water and Sanitation are also untrained. Discrepancies in training levels per programme can be explained by the nature of the programme:

- In Child health/ICCM and Malaria only basic tasks, such as distribution of mosquito nets, are expected of the CBVs. The treatment is administered by the health centre, not by the CBVs themselves
- Training levels are also linked to the presence of partners interested in supporting the programmes. The literacy programme, where just under 30% of CBVs are untrained, is not supported by the ministry, and is reliant on others, primarily CSOs, that are willing to support education projects and fund teacher trainings
- On many programmes, although no formal training is given, an orientation is given to instruct the CBVs of what is expected of them
- Moreover, some programmes have changed. The PWAS programme is gradually being replaced by the Social Cash Transfer programme, so no PWAS training has been delivered since 2004. The new PWAS recruits are therefore untrained, and only orientated.

Figure 8: Training levels per programme



KEY MESSAGE:

The training disparities suggest a re-assessment of the training packages given to each CBV under each programme. Large disparities are not beneficial to the communities in which the CBVs serve. All CBVs should be trained at consistent levels to maximize the impact of their help.

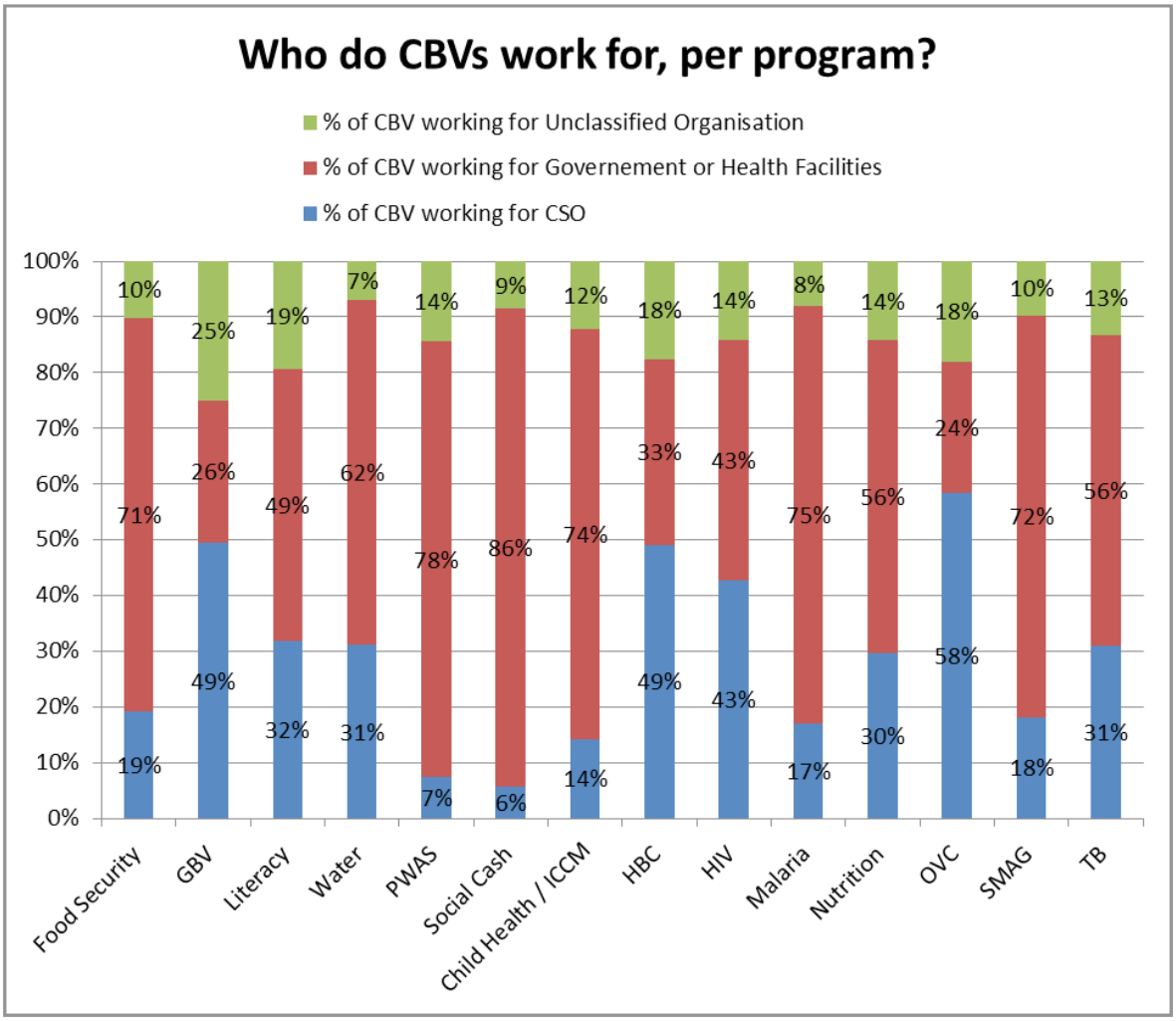
Moreover, the activities of the CBV have evolved over time. At first CBVs were requested to perform basic tasks, which did not justify a specific training, but tasks have shifted in nature. This also points at a need for re-training of the CBVs, primarily those not currently trained, but even those who have already received training.

CSO-Government partnership per Programme

The level of Government-CSO partnership varies across programmes.

As shown in Figure 9, CBVs working directly within Government management are most frequently associated with the following programs: Social Cash Transfers, Public Welfare Assistance Scheme, Child Health/ICCM, Food Security, Malaria, and SMAG. On the other hand, CBVs working with additional support by Civil Society Organizations are most frequently associated with the following programs: Orphans & Vulnerable Children, Gender-Based Violence, Home-based Care, and HIV/AIDS prevention..

Figure 9: Programmes that CBVs work for by organisation – Government, Health Facilities and CSO



CBV engagement in a programme differs greatly according to whether a programme is implemented by the Government or by a CSO.

This level of engagement can be noticed on the number of days that the CBVs work per week and the number of clients that the CBVs see per week. CBVs working for CSOs tend to work more days and see more clients than CBVs under the government. This can be explained by the differences in incentives that may arise from working for the government or working for a CSO. Although CBVs in different programmes have a very different workload, the incentives are not based on their performance, nor on their impact, but are linked to who funds the programme.

However, the differences in incentive levels are not the only reason for explaining such variations. Government CBVs also work on a government schedule. They might be engaged for specific activities or events (for Child Health week for instance), or on a limited number of days per month (like for the Social Cash Transfer programme). This also explains why CBVs appear to work less days when they work for the government compared to when they work for a CSO.

Since CSOs implement programmes with their own funding they are more likely to invest in the training of their CBVs. The CBVs are more likely to be trained if they work for a CSO. This suggests a homogenisation of the training levels across working under the government and under CSOs.

Continuum of Care

Very few CBVs worked for all the six programmes forming the continuum of care – water sanitation, malaria, SMAG, ICCM, HIV prevention, and nutrition.

Table 5 presents the number of CBVs working in all six programmes of the continuum of care per district.

Table 5: CBVs working in the continuum of care

Districts	Total number of CBVs	Number of CBVs working in all 6 programmes which define the continuum of care	% of CBVs working in the full continuum of care
Chilanga	586	7	1%
Chingola	1,651	2	0%
Chongwe	1,241	5	0%
Kafue	565	4	1%
Kitwe	999	18	2%
Luanshya	1,051	5	0%
Lusaka	2,073	20	1%
Masaiti	893	3	0%
Mufulira	663	0	0%
Ndola	936	14	1%
Rufunsa	394	5	1%
Total	**11,052**	**83**	**1%**

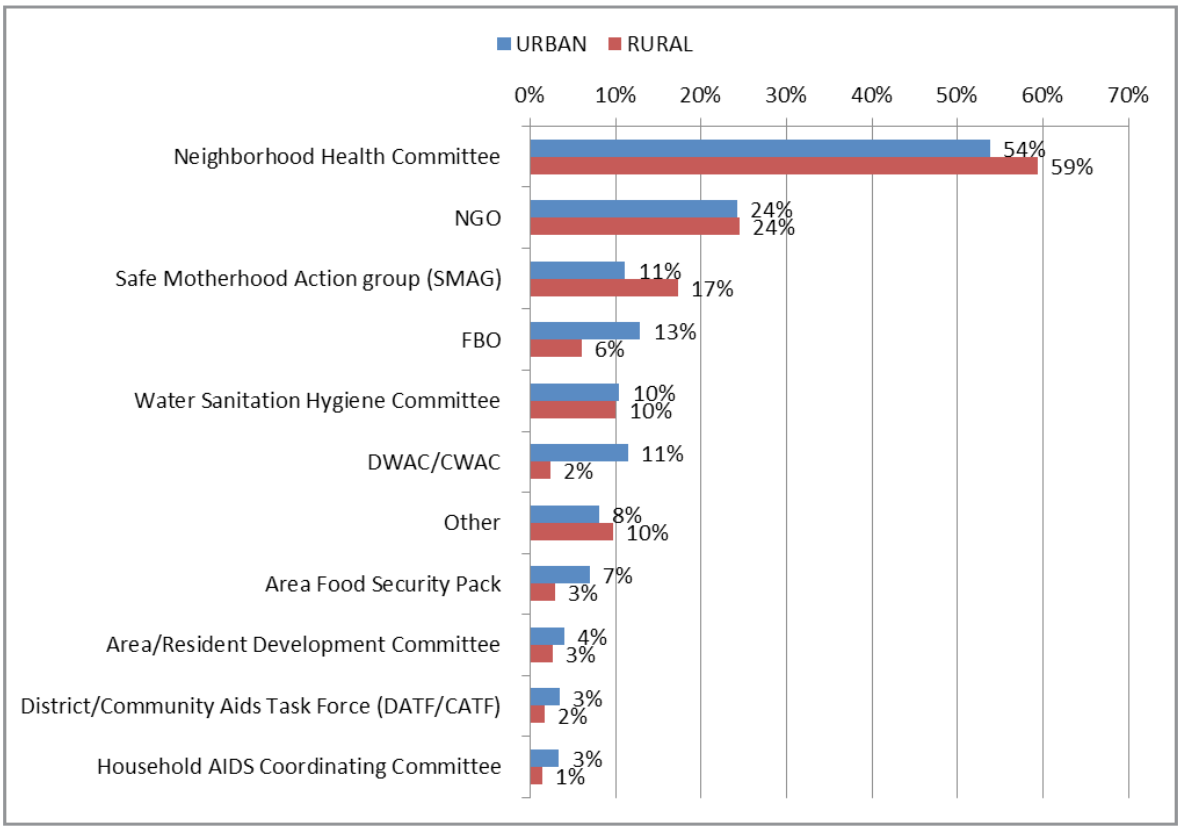
Furthermore, less than 0.5% of CBVs have been trained in all six training areas. This points to a need for more integrated programmes and training curriculum, which incorporates the most common health problems.

Committees

Committee Repartition

The largest committee is the NHC, both in urban and rural districts. The NHC draws 54% of CBVs in urban districts, and 59% in rural district as shown in Figure 10. The SMAG is also an important channel for getting in contact with CBVs in rural communities, as 17% of CBVs in rural districts also belong to the SMAG. However, it has to be noted, that the SMAG draw less CBVs in the three rural districts targeted by MDGi than in the other rural districts in Zambia. In the larger MCDMCH survey, 25% of the CBVs in rural districts belonged to the SMAG.

Figure 10: Proportion of CBVs in each committees – comparison Rural vs. Urban districts

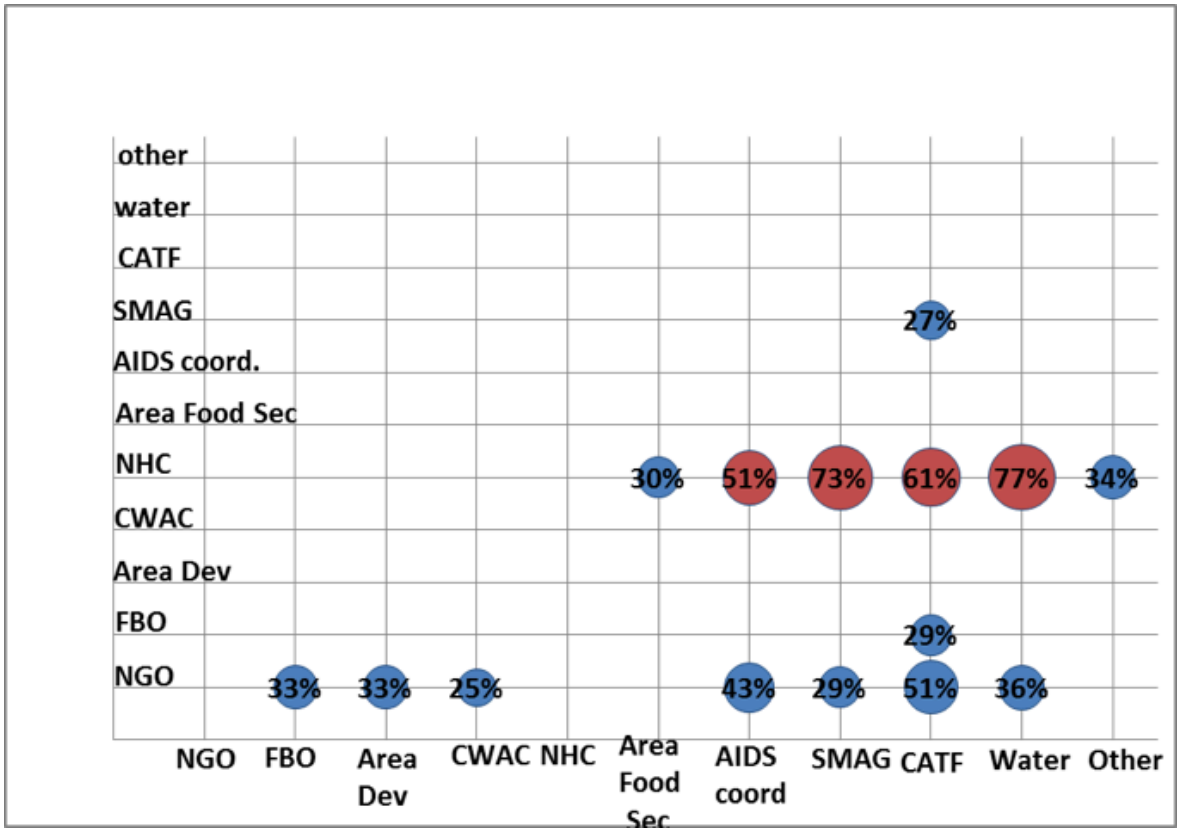


Committee Overlap

Analysis of the biggest committee overlaps suggest a fusion of some of the health related committees.

Figure 11 highlights the biggest committee overlaps. CBVs involved in the NHC are over 50% likely to also belong to the SMAG, the AIDS coordinating committee, CATF, and/or the water sanitation committee.

Figure 11: Biggest committee overlaps



Note: There are overlaps between all the committees, but for better readability, only overlap over 25% are shown in the graph.

KEY MESSAGE:
Committee structures should be simplified, as a large overlaps exist between committees in the health sector.

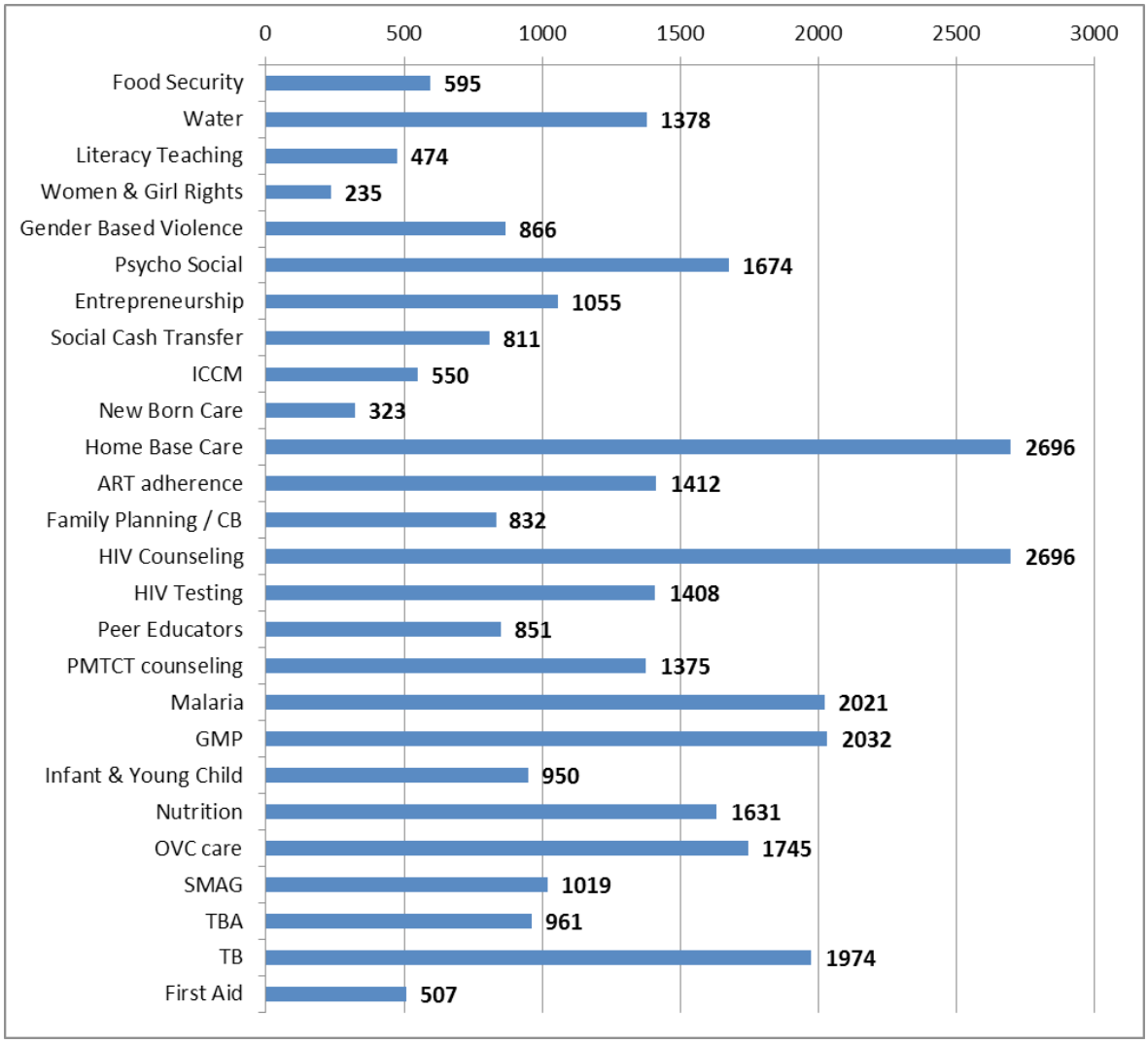
Training

Training Repartition

A large proportion of CBVs are trained in health specific training.

Different factors explain the dominance of health related trainings. Health has a lot more partners for capacity building in each clinical case (malaria, TB, HIV etc.), which explains the high representation of health related trainings. The historical HIV epidemic also explains why more trainings have been delivered in health, specifically in HIV counselling, HIV testing and ART adherence. The proportion of CBVs trained in each specific training area is detailed in Figure 12.

Figure 12: Proportion of CBVs that have been trained per training area

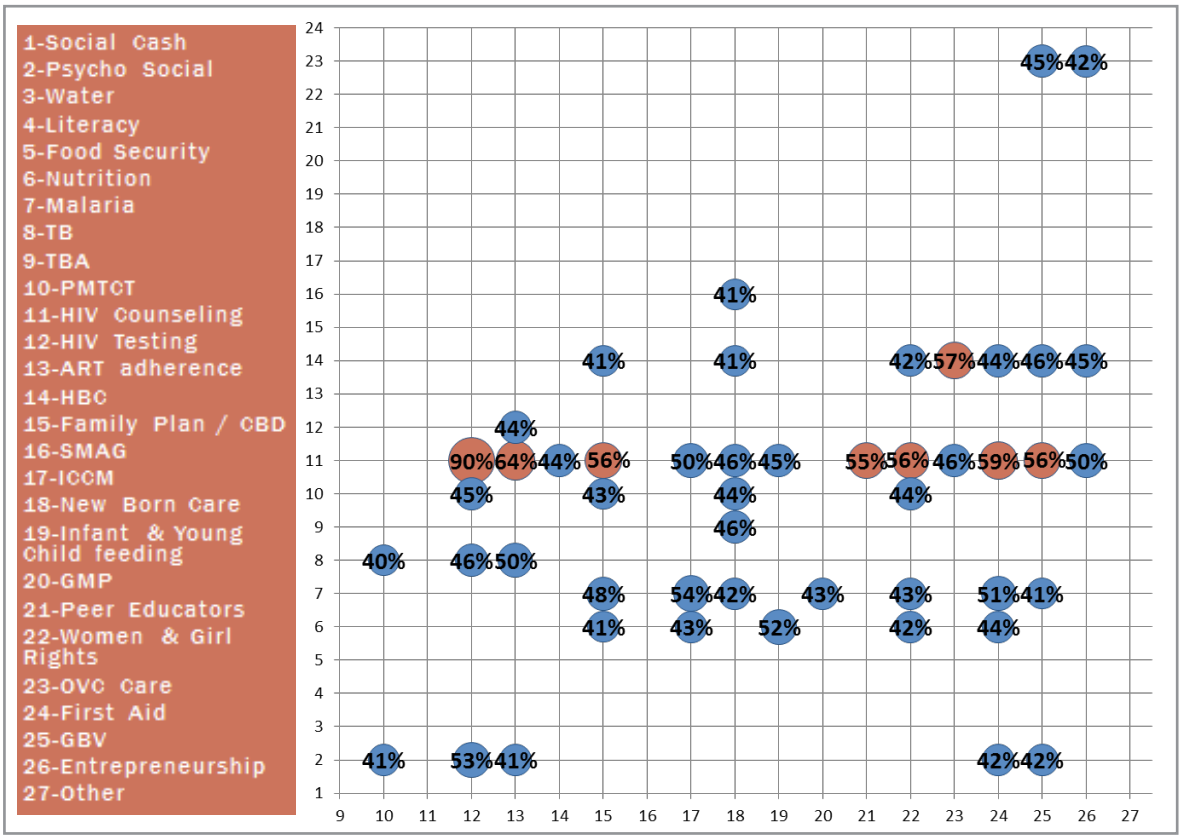


Training Overlap

CBVs have been trained in several training areas, whose overlapping characteristic suggests new training curriculums to enable CBVs to provide an integrated service of care to the communities.

The biggest training overlaps are between HIV counselling, HIV testing, ART adherence, Community Based Distributors, Peer Educators, Women and Girls Rights, First Aid and GBV, as highlighted in Figure 13. All these subject areas are related; so this finding is expected.

Figure 13: Biggest training area overlaps



Note: there are overlaps between all the training areas, but for better readability, only overlap over 40% are shown in the graph.

Training Recency

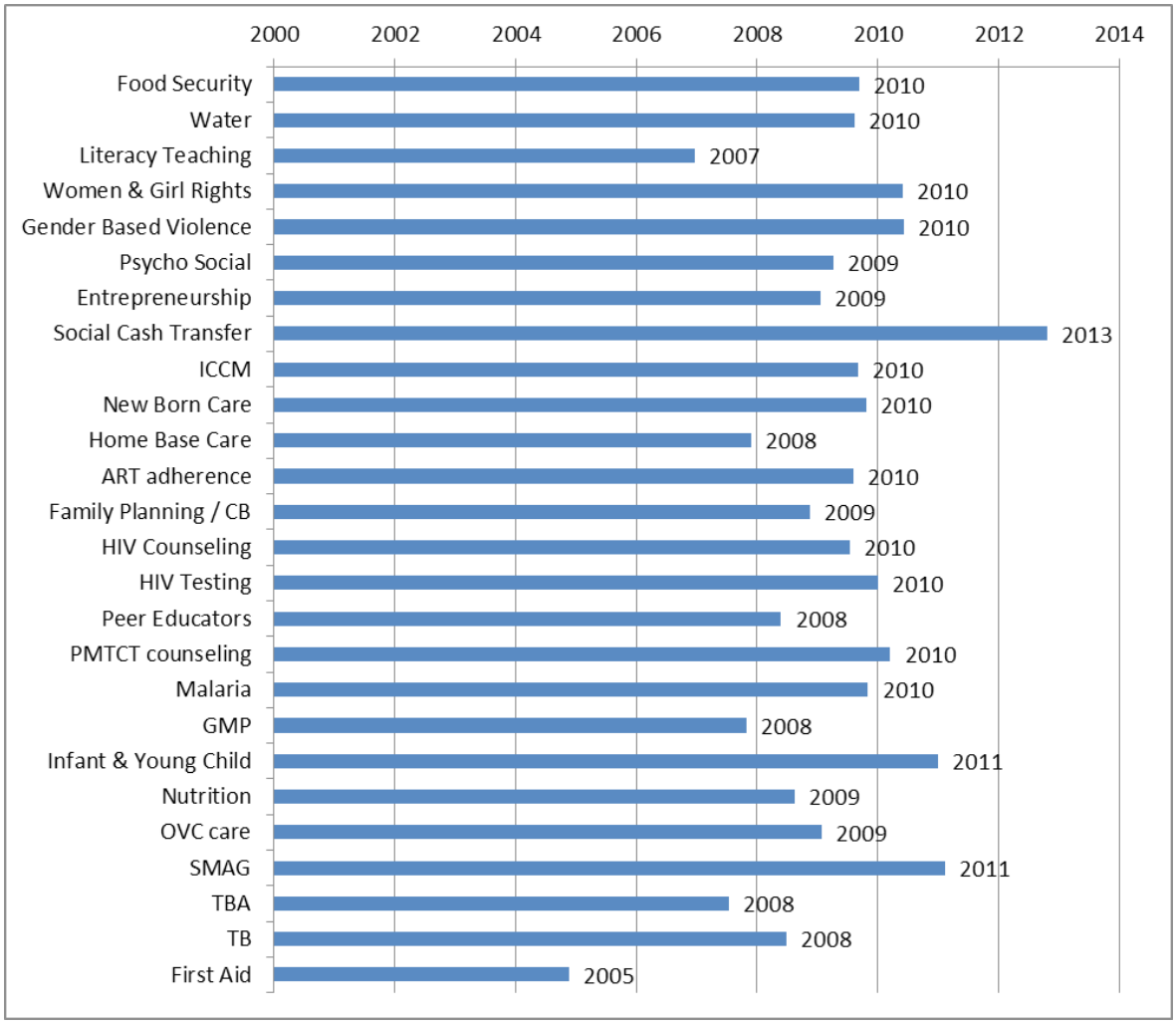
There are big differences per training area in terms of how recently the CBVs have received their last training.

Some training areas seem to have been neglected, as no training seems to have been taken place recently in the following areas: First Aid, Literacy, TBA, GMP, HBC, peer education, and TB. These findings are also reflected in the larger MCDMCH survey. There are different factors explaining this trend:

1. There has been a shift of trainings. TBA training has shifted into SMAG, whilst HBC has become less relevant
2. The trainings are reliant on partner funding and are not always well supported by the government.

Figure 14 highlights the last year (on average) where the CBVs were trained in five specific areas of interest with regard to the MDG Acceleration Initiative.

Figure 14: Year the CBVs were last trained on average per training area

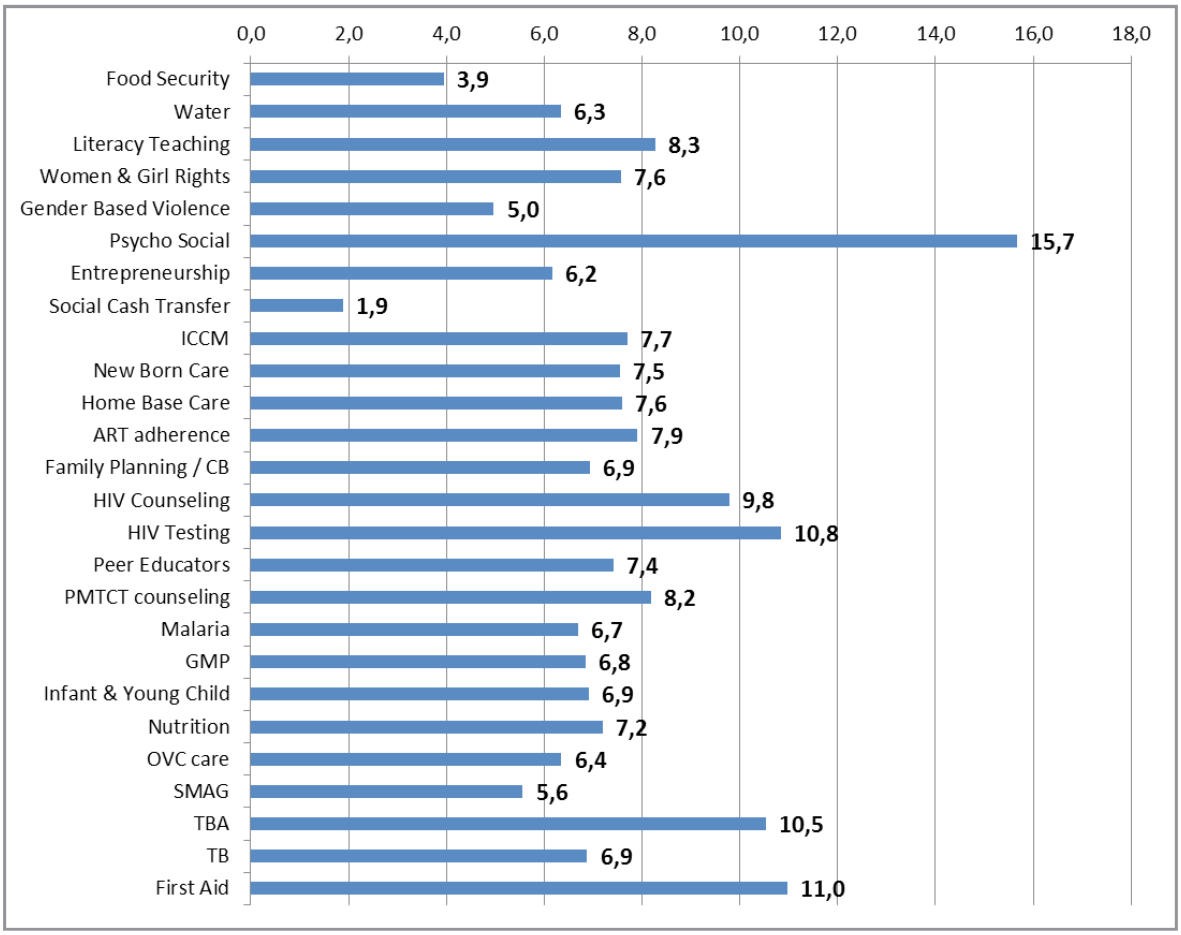


Training Length

Most trainings are around one week long (from 4-7 days on average), although there is a high variability of training length within one training area.

Training for TBA, First Aid, and HIV testing and counselling are on average around 10 days. In contrast, Social Cash Transfer has the shortest training duration of 1-2 days. The data for all training areas are reflected in Figure 15.

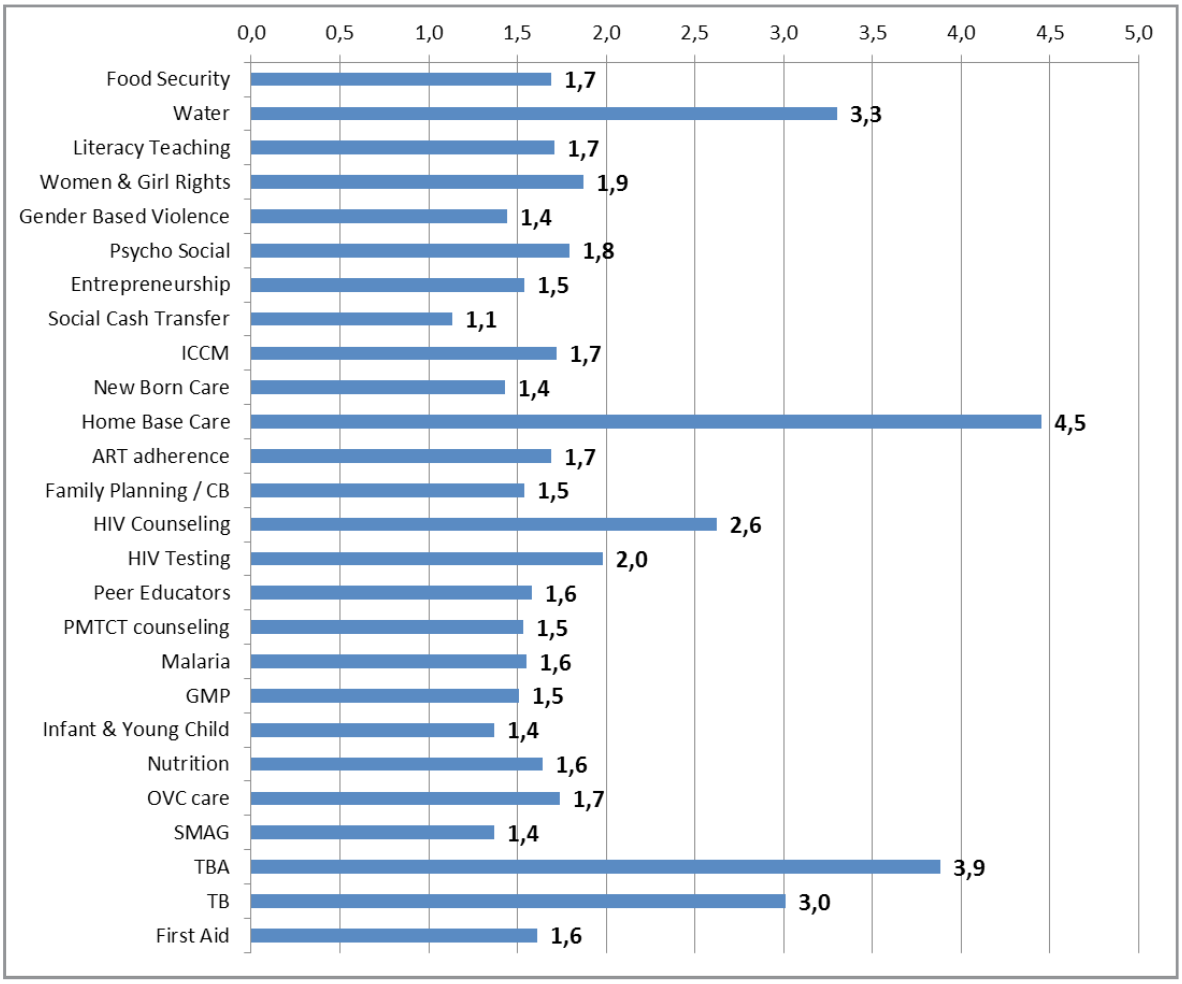
Figure 15: Average Length (in days) of the first training per training area



High variability is also noticeable in terms of how often CBVs are retrained.

The training areas which seem to be regularly run are TBA, Water and sanitation, TB, and HIV counselling and testing. In these areas, CBVs have received between 2-4 trainings in total, which suggests that they received training updates after their first initial training. However, the last training of these follow up trainings may still not have taken place recently. The data for all training areas are reflected in Figure 16.

Figure 16: Average Number of Training received overtime by CBV in each training area

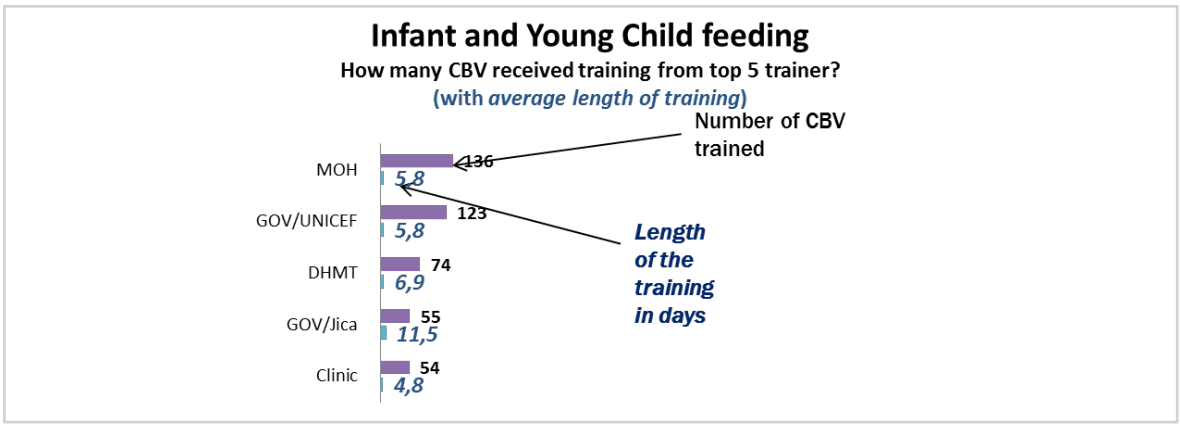


Differences per Trainer

Not only are there big differences from one training area to another, but within one training area. There are also big differences depending on who delivered the trainings.

In Infant and Young Child feeding for instance, the average training delivered by the government funded by UNICEF is around six days, shorter on average than the same trainings delivered by the government and funded by JICA, which are around 11 days.

Figure 17 : Differences of training lengths per trainer



KEY MESSAGE:

Ultimately, the different training being provided creates disparities in the way CBVs are trained and calls for a harmonisation of training curriculums, in order to maximise the impact of the CBVs on their communities. The combining of training areas into a multi-facetted training curriculum would also help the CBVs to provide better integrated services to the communities.

Incentives and Motivation

89% of CBVs stated helping other in the communities as their biggest motivator.

Trainings and skills are commonly received as incentive for becoming a CBV (in 48% of cases). Money is also given quite often, in 25% of cases, and regarded as an important incentive. However, this varies a lot depending on who delivered the training, as CSOs are more likely to give money (and more money) than the government.

Table 6 : Itemisation of incentives

Incentives?	Number of CBVs	%
trainings / skills	5,264	48%
T-shirts	3,941	36%
certificate	3,807	34%
money	2,831	26%
bicycle	2,242	20%
boots	1,606	15%
other	1,377	12%
umbrella	1,353	12%
food/supplements	889	8%
parties	260	2%

26% of CBVs receive money (usually less than K30 per day) or goods from their organisation, or from their clients in exchange for their services.

Over 25% of CBVs stated that their incentives have decrease or stopped completely over time.

As a consequence of changing incentive levels, drop-outs rates of over 30% can be noticed in certain programmes.

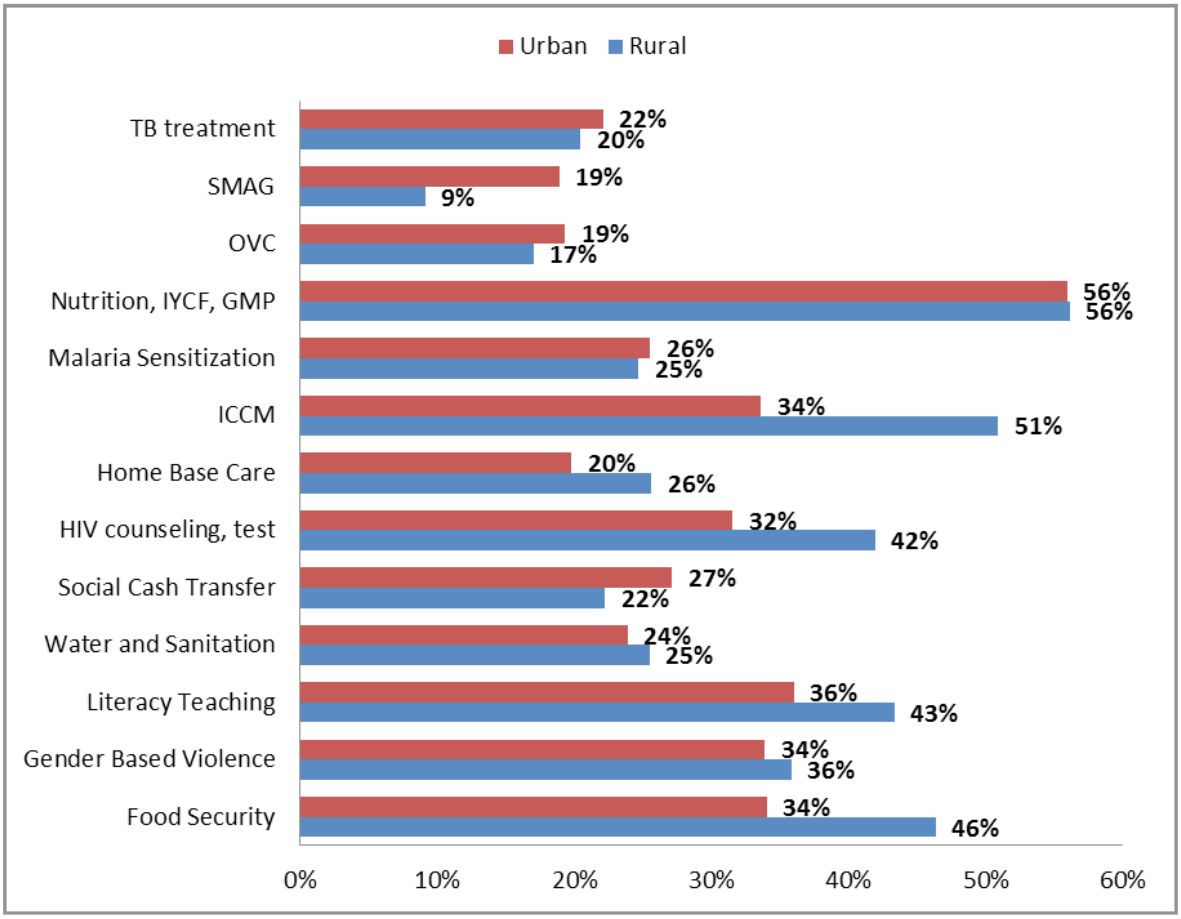
The programmes that seem to have the most drop outs are Nutrition (56% drop-outs), Literacy (40%), Food security (40%), GBV (35%) and ICCM (42%). In contrast SMAG and OVC have the lowest drop-out rates, especially in rural districts with 9% and 17% drop-out rates, respectively. This is a good sign for the continuity of the service delivery in the communities. Figure 18 details the drop-out rates per programme in rural and urban districts.

These findings differ significantly from the MCDMCH survey. The case of ICCM is particularly different. In other rural districts surveyed in the MCDMCH survey, the drop-out rate for ICCM was just 26% compared to the 51% noticed in the three rural districts targeted by UNICEF. Another notable difference is that the proportion of drop-outs in rural districts is higher than in urban districts, especially in the programmes of ICCM and HIV counselling and testing. This differs from the MCDMCH survey where there are generally more drop-outs in urban districts than in rural districts. There are different factors that explain the varying dropout rates:

- Food Security CBVs can only work for two years, and need to be re-elected. Therefore it is expected to have a high number of CBVs who have been trained in that area, but no longer work there if they have not been re-elected. Food Security targeted district areas may also have changed, triggering a turnover of CBVs
- The high urban drop-out rates may be explained by the fact that CBVs get into volunteering with the hope of securing a permanent job. When the situation turns out differently they drop-out

- The incentive levels may change over time as funding sources and programmes change
- The implementation of the Social Cash Transfer programme relied on a control group and a treatment group. The CBVs that were in the control group were trained for this programme but were not expected to work in the programme. This would create fake drop-outs in the results.

Figure 18 : Drop-out rates per program and district profile



KEY MESSAGE:

The disparities of incentives amongst CBVs cause problems in terms of the sustainability of the programmes. CBVs are likely to drop-out when incentive levels change. It is difficult to set a right incentive that motivates all CBVs, while maintaining a spirit of voluntarism, and not making the CBVs incentive-dependent. Incentive levels are not linked to the workload and performance of the CBVs but to the funder of the programmes.

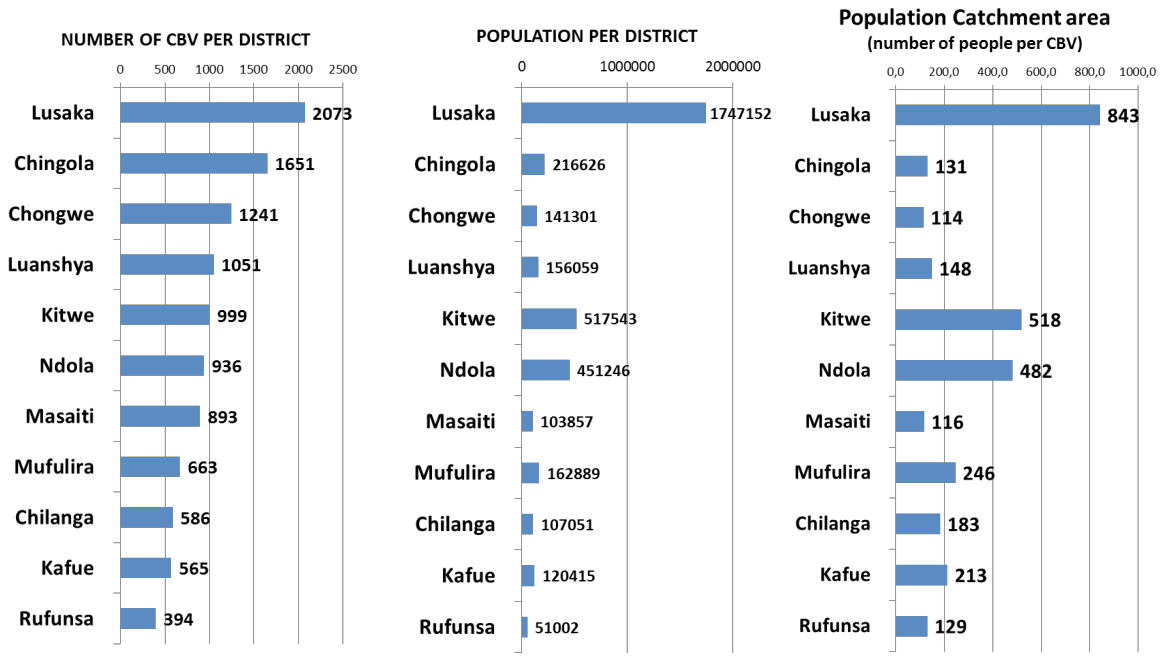
This calls for guidelines to harmonise the incentive levels so that both government and CSOs reward the CBVs for their work fairly and equally, which will help to prevent competition between programmes. Drop-out rates should decrease as a result of a more homogeneous approach to incentivising the CBVs.

Micro Planning and Geographical Coverage

The size of the population catchment area of for a CBV varies greatly from district to district.

As expected, CBVs in urban areas have larger population catchment areas than CBVs in rural areas. However, there are differences within urban areas. In Lusaka, there are over 1,000 inhabitants per CBV, while in Ndola and Kitwe it is around 500. Other urban districts have smaller population catchment areas per CBVs. In rural districts, there are around 110 persons per CBV on average.

Figure 19: Population Catchment Area per CBV per district



Impact of the size of the CBV population catchment area per program

Given that different programmes require different level of involvement from the CBVs, large population catchment areas can be problematic, as CBVs cannot deliver consistent and timely care to all community members in highly dense catchment areas.

The number of clients seen per week varies a lot from programme to programme. ICCM is characterised by two outreach activities per week. This explains that ICCM scores high number of clients seen per week. HBC in contrast involves giving individualised help to bedridden HIV and AIDS or TB patients, which explains that CBVs who deliver HBC see a relatively low number of clients per week. The population pressure is therefore higher for CBVs who are active in the HBC programme than for CBVs who are active in the ICCM programme. The capacity building of CBVs should take into account the population pressure in the areas where the CBVs are recruited, as the needs will differ in highly dense population areas and in rural areas.

Figure 20: Average number of clients seen per week per CBV per programme

Micro Planning at Ward Level

The planning of activities in each of the 11 districts is facilitated by information about population catchment area at ward level. For example, for Rufunsa district:

Table 7: Distribution of CBV per ward – example of Rufunsa district

Ward	Number of CBVs	Population per ward	Population per CBV	Households per ward	Households per CBV
Rufunsa	141	15,724	112	2,881	20
Bunda Bunda	99	14,305	145	2,621	27
Nyangwena	58	7,631	132	1,327	23
Shikabeta	37	1,954	53	362	10
Nyamanongo	25	2,983	119	499	20
Mwachilele	18	4,363	242	794	44
Mankanda	12	4,042	337	813	68
Unknown	4				
District Total	**394**	**51,002**	**130**	**9,297**	**24**

This information highlights the varying concentration of CBVs at ward level in a specific district. This variation should be taken into account when planning activities at ward level. Information about the distribution of CBVs per ward in all the 11 districts in the UNICEF survey is available in the Excel data reports.

Within each ward, there is also a varying concentration of CBV per program, as highlighted in the table below which takes for example Rufunsa district. Information about the distribution of CBVs per ward and per programme in all the 11 districts in the UNICEF survey is available in the Excel data reports.

Table 8 : Distribution of CBV per ward per programme - Example of Rufunsa district

Ward	Malaria	TB	Safe Mother-hood	Child Health/ ICCM	HIV	Nutrition	TOTAL
Rufunsa	32	27	28	12	38	16	**141**
Bunda Bunda	37	7	24	10	16	10	**99**
Nyangwena	25	4	19	12	20	7	**58**
Shikabeta	16	9	19	3	8	5	**37**
Nyamanongo	8	4	2	2	1	1	**25**
Mwachilele	.	.	4	.	4	.	**18**
Mankanda	2	2	10	2	3	.	**12**
Unknown	1	.	1	.	2	1	**4**

Micro Planning at Health Facility Level

The planning of activities in each of the 11 districts is facilitated by information about the number of CBVs per health facility. For example, for Rufunsa district:

Table 9: Distribution of CBV per health facility – example of Rufunsa district

Data Collection Posts / Health Facilities	Number of CBVs	%
Chifundo HC	1	0%
Chimusanya HP	16	4%
Chinyunyu HC	19	5%
Chiyota HP	18	5%
Kankumba HC	86	22%
Kazemba Clinic	9	2%
Luangwa Bridge HC	17	4%
Lukwipa HC	1	0%
Mpanshya Hospital Affiliated HC	41	10%
Mpanshya Mission Hospital	18	5%
Mulamba HC	13	3%
Namanongo HP	18	5%
Nyangwena HC	38	10%
Rufunsa HC	11	3%
Shikabeta HC	37	9%
Other	50	13%
Unknown	1	0%
TOTAL	**394**	**100%**

Similarly, this information highlights the varying concentration of CBVs per facility in a specific district. This variation should be taken into account when planning activities at facility level. Information about the distribution of CBVs per health facility in all the districts is available in the Excel reports.

RECOMMENDATIONS

This section sets out some recommendations for the areas that the ministry should focus their attention on to improve the utilisation and the coordination of the CBVs based on the survey findings and a review of these findings with the district officers who implemented the MCDMCH survey in the 30 districts, and in the additional seven districts covered by UNICEF.

1. **Re-assessment of the selection criteria for programmes to allow more women to become a CBV**. Higher prevalence of male CBVs in rural areas in programmes like ICCM or Gender Based Violence prevents an effective reach of the CBVs towards all people in the communities, especially towards women

2. **A simplification of the programmes being delivered in the communities**. Large overlaps between programmes suggest that some programmes may be good candidates for being combined

3. **Committee structures should be simplified**. Overlaps exist between committees in the health sector. In addition a common point of contact for all CBVs would help to facilitate better coordination of the volunteers

4. **Re-assessment of the training packages given to each CBV under each programme**. In some programmes a high proportion of CBVs are delivering services to their communities without having received any formal training. All CBVs should be trained to maximise the impact of their work and of their skills. CBVs having been trained over two years ago should have the possibility of getting refresher training, particularly as the nature of the tasks expected of them may have changed and require additional training to maintain the quality of the services that they are providing to the communities

5. **Harmonisation of training curriculums in order to maximise the impact of the CBVs towards their communities**. Combining training areas into a multi-facetted training curriculum would also help the CBVs to provide better integrated services to the communities

6. **Harmonisation of incentives amongst CBVs.** The disparities that exist in the incentives being offered cause problems in terms of the sustainability of the programmes. CBVs are likely to drop-out when incentive levels change. Incentives should be linked to the workload and performance of the CBVs

7. **Development of a CBV MIS system**. All of the data gathered under the MCDMCH and UNICEF surveys should be used as the first building block to introduce a fully functioning MIS system giving the surveyed districts access to the CBV data. Such a system would allow the district officers to maintain up-to-date information (add new CBVs, modify the details of existing CBVs etc.). It would provide the districts with a fresh baseline of information to guide the decision making process for the planning of new activities at district level. The data should also be accessible to the Ministry to provide a holistic view of the number of CBVs in the country and identify possible gaps. Finally the data should be made available to other partners, in order to facilitate the planning of activities by these partners.

8. **Expansion of the survey.** The survey should be rolled out in the remaining districts in Zambia that were not part of the original survey to complete the picture of the state of the skills and structures of CBVs in the country. This would allow all districts to have access to detailed data to plan district and community level activities. The roll out of the survey in other districts could be combined with the implementation of the CBV MIS system.

ANNEXES

Annex 1
CBV Repartition per programme per district

	Social Cash Transfer	Food Security Pack	Water and Sanitation	Public Welfare Assistance Scheme (PWAS)	Literacy	Orphans and Vulnerable Children (OVC)	Home based care (HBC)	Malaria control	TB	Safe Motherhood	Child Health / ICCM	HIV	Nutrition	Gender Based Violence	Other	TOTAL
	3%	3%	7%	3%	2%	9%	12%	11%	8%	7%	9%	13%	7%	3%	4%	100%
Rufunsa	0%	1%	9%	2%	1%	6%	9%	16%	7%	14%	5%	12%	5%	4%	7%	100%
Mufulira	0%	4%	2%	2%	2%	11%	18%	10%	8%	8%	8%	12%	6%	2%	6%	100%
Chilanga	0%	6%	8%	3%	4%	7%	11%	14%	6%	5%	6%	14%	7%	4%	5%	100%
Kafue	0%	3%	10%	5%	2%	7%	11%	11%	8%	10%	7%	11%	6%	3%	6%	100%
Masaiti	1%	2%	6%	4%	1%	8%	8%	10%	7%	18%	7%	14%	8%	3%	4%	100%
Chingola	0%	10%	4%	12%	4%	9%	12%	7%	6%	6%	10%	10%	5%	1%	4%	100%
Chongwe	0%	2%	12%	0%	1%	10%	13%	17%	4%	8%	6%	14%	6%	2%	4%	100%
Luanshya	5%	2%	3%	4%	2%	12%	12%	9%	7%	8%	9%	15%	4%	3%	5%	100%
Ndola	3%	1%	7%	3%	1%	11%	10%	12%	7%	6%	16%	10%	6%	4%	3%	100%
Kitwe	2%	2%	10%	1%	2%	7%	9%	13%	10%	5%	12%	15%	7%	4%	3%	100%
Lusaka	8%	1%	6%	1%	2%	8%	14%	6%	10%	4%	7%	16%	10%	5%	2%	100%

Annex 2
CBV Repartition per committee per district

	Neighborhood Health Committee	NGO	Water Sanitation Hygiene Committee	Other	FBO	Safe Motherhood Action group (SMAG)	Area/ Resident Development Committee	Area Food Security Pack	District/ Community Aids Task Force (DATF/ CATF)	Household AIDS Coordinating Committee	DWAC/CWAC
rufunsa	215	93	39	47	20	86	12	8	11	3	21
mufulira	301	133	44	95	127	107	36	59	30	37	47
chilanga	273	209	67	85	137	61	45	91	34	37	37
kafue	377	164	121	57	40	119	27	49	28	27	104
masaiti	587	262	84	98	36	254	17	38	15	20	32
chingola	507	138	62	155	35	138	41	212	22	34	188
chongwe	699	263	131	100	98	97	37	28	16	14	9
luanshya	549	378	41	72	107	167	37	52	52	25	184
ndola	732	207	111	68	133	141	45	28	39	49	204
kitwe	761	206	176	53	106	82	33	52	41	29	100
lusaka	1084	632	268	109	412	135	84	53	50	53	112

Annex 3
CBV Programmes per Department

Programme	Department
Social Cash Transfer	SW
Food Security Pack	CD
Water and Sanitation	CD
Public Welfare Assistance Scheme (PWAS)	SW
Literacy	CD
Orphans and Vulnerable Children (OVC)	Health
Home based care (HBC)	Health
Malaria control	Health
TB treatment	Health
Safe Motherhood Action Program (SMAG)	Health
Integrated Child Care Management (ICCM/IMCI) / Child Health	Health
HIV prevention	Health
Nutrition	Health
Gender Based Violence	CD
Other	Other

Annex 4

Matching of Programmes and Training Areas (for drop-out analysis)

	Programme		Training
1	Social Cash	1	Social Cash Transfer
3	Water	3	Water
5	Literacy	4	Literacy Teaching
2	Food Security	5	Food Security
13	Nutrition	6	Nutrition
		19	Infant & Young Child Feeding
		20	GMP
8	Malaria	7	Malaria
9	TB	8	TB
12	HIV	11	HIV Counselling
		12	HIV Testing
		13	ART adherence
		10	PMTCT counselling
		15	Family Planning / CB
		21	Peer Educators
7	HBC	14	Home Base Care
10	Safe Motherhood	16	SMAG
11	Child Health / ICCM	17	ICCM
		18	New Born Care
6	OVC	23	OVC care
14	GBV	25	Gender Based Violence

Annex 5
Classification of Organisations into CSOs and Government

Row Labels	Sum of count
GOVERNMENT	28507
Catf	39
CHAZ	1
CHO	3
Community	2
Community Based Care Foundation	100
Community Based Worker	1
Community Committee	8
Community Development	1120
Community Food Security Pack	1
Community Health Centre	1
Community Health Organisation	2
Community Health Rp	1
cooperative	1
Council	210
CWAC	20
D/CWAC - PWAS	95
DATF	36
DCHO	8
DCHO	88
DCMO	1
DCMO	42
DCS office	15
Department Of Water Affairs	6
Development Agency	2
DHMI	2
DHMO	41
DHMT	3
DHMT	2665
DHO	46
DHO	1520
DHS	1
District	16
District	2
DMO	16
DMO	28
EHT	1
Family Health Planning	1
Family Health Post	1
food security	19
Foreign Affairs	2
GOV/CDC	28
GOV/Danida	4
GOV/DFID	4
GOV/EU	2
GOV/fao	1
GOV/FINCA	2
GOV/Irish Aid	5
GOV/Jica	711
GOV/Mamaz	366
GOV/SUFP	125
GOV/TB CARE	9
GOV/TB CARE	66
GOV/UKAID	10
GOV/UNAID	71
GOV/UNAIDS	2

GOV/UNAIDS	33
GOV/UNDP	4
GOV/UNDP	7
GOV/UNESCO	2
GOV/UNFPA	618
GOV/UNFPA	17
GOV/UNHCR	81
GOV/UNHCR	72
GOV/UNICEF	6
GOV/UNICEF	554
GOV/USAID	31
GOV/USAID	215
GOV/WFP	31
GOV/WHO	71
GOV/World Bank	7
GOV/ZISSP	10
GOV/ZISSP	329
Governement	35
GRZ	65
GRZ	398
Health	25
Home affairs	10
Home Base Care	6
Home based care	181
HSSP	1
Local Goverment And Housing	20
MCDMCH	4
MCDMCH	5199
Ministry Of Agriculture	122
Ministry Of Chiefs And Traditional Affairs	3
Ministry Of Commerce	1
Ministry of Defence	18
Ministry of Education	91
Ministry of Finance	1
Ministry of Gender	2
Ministry Of Home Affairs	29
Ministry of Labour	1
Ministry Of Local Government	70
Ministry Of Mines	2
Ministry Of Water Affairs	2
Mobilizing Access To Maternal Health In Zambia	1
MOG	1
MOH	6
MOH	4680
Mother and Child Health	4601
Municipal Council	6
National Aids Council	6
National Food And Nutrition	5
National Legal Aid	1
National Malaria Control Center	71
National Mental Health Centre	1
NHC	82
Norad	3
Not classified	2
OP	8
Other	149
PCI	303
PEPFA	14
PHO	2
PMO	2
Police	77
PWAS	1
PWAS	5

Resident Dev Committee	2
RHC	6
RHC	68
science	1
SMAG	24
Social Cash Transfer	3
Social Cash Transfer	34
Social Welfare	34
Social Welfare	2340
Water Affairs	9
zaf	5
ZISSP	7
Health Facility	963
Clinic	82
Health Facility	2
St Agness H/C	84
St Dorothy	97
St Francis	327
St Johns	51
St Lawrence Hbc	29
St Luke's Clinic	42
St Pauls Hospital	30
Thandizani Hbc	219
HEALTH FACILITY	4002
Clinic	3780
Katondwe	6
Our Ladys Hospice	10
UTH	206
NGO/FBO/PRIVATE	32859
aar japan	4
Africa Care	6
Africa Impact	13
Akross	7
Akross	15
Amda	3
Antioc	1
Arha	2
bible society	2
BIZAIDS	2
Boston University	19
Bright Children	2
Bwafwano	9
Bwino Suport Group	5
Care	396
Care	101
Caritas	795
Caritas	15
Catholic Church	189
Catholic Womens Council	1
CBO	10
CBOH	1
CBZ	1
CCAF	4
CCAP	2
CCF	14
CCHC	1
CCI	4
CCNP	9
CDCHO	9
CDM	19
Cdmtc	11
Celim	2
CFF	1

CFH	2
cfo	1
CFTC	1
Champ	32
Champ	141
Champion	1
changes	11
Chapter	9
Charity Ministries	4
Chase	1
CHAWMA	98
CHAZ	14
Chaz	2080
CHEP	3
Chep	1326
Cheshire Homes	12
Cheza	10
Chichetekelo	42
Child care	1
Child Development	1
Child Food	1
Child Fund	207
ChildFund	263
Children Care	2
Children cry	8
Children International	56
Children With Future In Zambia	6
Chin	13
CHREP	238
Chreso Ministries	14
Chreso Mnistries	17
Christian Centre	3
Christian Council Of Zambia	5
Church	2
Church	1507
CICP	1
CID	1
Cidrz	1
Cidrz	3021
Cinci Wababili	8
Cindi	125
Circle Of Hope	12
cisep	8
CMMB	6
Coataz	2
coheip	123
Comaco	18
Combo	1
Combor	50
Concern	180
Concern	19
connect	1
contesa	1
Cool Food Company	1
cooperative	1
Corridors of Hope	25
Cortaz	6
Council	1
covic	1
CPFZ	1
Craids	122
Craso	6
creso	2

CRS	390
cruza	4
crv	1
ctc	1
cts	1
CTYA	2
cusa	3
Cym	9
dagama	4
Dakana	44
DAPP	2
DAPP	174
Diaconia	11
Diocese	8
Diocese	1089
Disciple Fellowship Ministry	1
Divine Health	5
dove	2
Drama	5
D-Wash	1
D-Washe	145
ECF	1
ECR	616
ECZ	3
EDU	10
edusport	25
EEc	4
EFZ	30
Eliashib	3
Elizabeth Glasier	31
Emmanuel Trust Care	1
encounter ministry	1
EPWA	7
Evangelical Church	4
Evelyn Hone	3
Every Home For Christ	15
Fabric	11
faith of hope	2
Families in Distress	2
Family Health Trust	68
Family Life	1
Family Matters	17
Fao	45
Farming Input	25
Faweza	22
FBO	199
FHI	4
Fhi360	7
FHT	1
fica	1
First Aid	1
First Quatum	2
fiwamina	2
FOM	2
Forge	7
Gamma Chuulu	36
Gender Links	3
Gfc	67
GFFMI	1
givelife	11
global health learning	2
global network	76
Goh	7

Good Hope	6
Grace Of Hope	5
Grass Root Soccer	5
Grassroot Soccer	3
Hand At Work	118
hands of hope	1
Happy Childern	11
HCC	5
hcp	1
Health Communication Partnership	6
health trust	1
Healthy	8
Heaven Of Hope	2
Help International	2
Henwood Foundation	13
Hiv/Aids Group	2
HODI	176
Home based care	1
Hope	51
Hope And Love Foundation	1
Hope For Grieving Children Africa	3
Hope For Hopeless Care Support	1
hope for life	1
Hope Humana	113
Hosana	23
House Of Moses	7
Human Resource	5
iluka	2
Insight	1
inter health	1
International AIDS Alliance	2
Intra Health	5
Intra Health International	16
Ipa	12
iseni	13
Islamic Council Of Zambia	3
Jata	74
Jehova	1
Jesus Care	24
Jesus Care International	15
Jesus Cares Ministry	42
Jhpiego	7
Jhpiego	126
John Laing Home Base Care	10
Kachafwama	3
Kacoshai	17
Kansanshi Foundation	20
Kara	488
Kasis	17
KCM	9
kdc	1
Kdcmo	182
Keeper Zambia Foundation	13
Keepers Zambia	8
Kerith Project	28
Kuchafwana	4
Law Association Of Zambia	3
LCC	2
Liberty House	84
Liberty Training College	4
Light Of Hope	37
Linkages	39
Lions Club	6

Long Life	26
Lswc	8
Luanshya Support Group	31
Luapula Foundation	49
Ludhmt	5
Lumwana Mine	61
Lumwana Mining	15
Lusaka Health Trust	33
Lusaka Water & Sewerage Company	10
Lusaka Water Sewerage	7
Luse Lwamfumu	5
LWSC	12
Maano Kwabana	13
Macha Research Trust	16
mafl	1
Malaria Consortium	481
Mapepe Bible College	9
Mapp	1
March Zambia	3
Marriage Guidance	3
Mayo Wabana	4
Mental Health Association	1
Messiah	67
MHPF	3
Micro Credit	1
Micro Trust Bank	1
Mikomfwa Home Based Care	28
Millenium Development Goals	2
mine	5
Mission Direct	6
Mitengo	14
mmm	3
Mopani	
Mopani	250
Mopani Mine	4
Mother Of Mercy	311
Mother To Mother	19
Mother without borders	1
Mpatamatu Home based Care	1
Mpima Health	8
MSF	93
Mtendere Hiv Group	6
Mulonga	10
Mulumbo Early Childhood Care And Development	1
Murundu	1
Nation Food Nutrition	3
National Association Of Child Care Workers	1
National Mental Health Centre	2
Natwas	1
Nazarene Compassionate	5
Needs Care	20
New Start	315
NFA	38
NGO	720
NGOCC	3
nipa	1
Nkana Water & Sewage Company	13
NMC	5
Noahs ark	3
Nofred House	1
Not classified	3
Nsansa	3
NWSC	10

NZHIV+	1
NZP	1
NZP+	38
NZPT	24
Olive Leaf Foundation	4
One Stop Centre	1
Other	6477
oxfam	32
Palliative Care	15
Pamu	2
Pan African	4
PCC	6
PCI	29
Peace Corp	19
Peace Corps	78
Pilgrim Salt Community	11
Plan	17
Platform For Youth Dev	6
PNG	69
POG	4
Population Council	9
Positive Community Impact	1
PPAZ	605
Pricho	11
Pride	17
Pride Community	12
Pride Safe Love	3
Prism	23
Prison	4
Private	3
Private Mine	4
Program For Youth Development	1
psf	2
PUC	107
pulse	1
Rainbow	102
Ranchhod	220
Rapids	137
RCZ	2
recap	8
Recs	1
Red Cross	1
Red Cross	156
REDNESSS	1
Renato	8
Restless	9
Restless	8
Ribat College	3
Ricap	28
Rights To Play	5
Rising Fountain	4
Riverside Farm Institute	28
Rotary Club	51
Rural Water Suply	51
Safaid	24
Safaid	23
Safe	4
Safe	16
safe love	22
Salvation Army	301
Sandkiv	5
Sandvik	1
Sao	2

Sao Zambia	14
Sap	25
Save The Children	15
Save Zambia	63
scred heart	1
Seed of Hope	1
Seed of Hope	150
seeds of health	1
seeds of hope	26
SEPO	4
serve	6
Serve Zambia Foundation	112
sezafo	2
SFH	132
SHA	73
SHA	16
Shape	21
Share	29
Sharpz	9
sight savers	32
Snv	12
Society for Family Health	20
Society For Family Health	149
Society For Women Zambia	6
Sos Children Village	11
Splash	2
Sports In Action	4
Stamp	4
Stamp	10
Steps OVC	260
Steps OVC	302
SUFP	6
Swaaz(Society For Women)	7
SWAZ	9
Synod	10
Tahan	24
Talc	1
Talc	7
TB Care	4
Tiny People Matter	18
Tipec	19
TSA	53
UCZ	3
UCZ	74
Ummi	25
URDZ	2
Water Aid	61
Window Of Hope	32
Vocational Training Centre	1
Women of Charity And Care	9
women on the move	3
Women Peace makers	3
World Hope International	1
World Vision	9
World Vision	1434
VSO	32
Wuz	8
V-Washe	46
WVI	25
Xantas	1
YMCA	24
Youth & Child Care Foundation	1
Youth Aganist Hiv/Aids	4

Youth Alive	3
Youth Community Tranning Centre	1
youth friendly	1
Youth Of Influnce	6
youth resources	2
Youth Sport And Child Development	1
Youth With A Dream	22
YWA	13
YWCA	5
ZAC	43
Zambart	205
Zambia Anglican Council	3
Zambia National Kids Council	1
Zamcat	1
Zamind	1
Zaminds	62
zamsif	1
ZAP	1
Zapid	2
Zaweda	8
ZCC	2
Zcc Zambia Counseling Council	104
ZCPT	7
ZDA	1
Zedao	21
zedao	8
ZEHRP	167
ZERP	2
ZHECT	3
zherp	32
ZHETC	2
Zigo	1
ZIHP	20
Zingo	24
Zndf Livingstone	1
ZNFU	1
ZNP+	7
ZPCT	226
ZPI	1
ZPI+	8
ZPTC	1
ZRC	12
ZRCS	1
Not classified	4923
	3
Not classified	4909
Repssi	9
SFH	2
Grand Total	**71254**