

Prevention of Mother to Child Transmission Project Luansobe, Northern Zambia

PROJECT SUMMARY

The project seeks to reduce level of transfer of HIV/AIDS from pregnant/lactating mothers to their new-born babies through the following ;

- strengthening the Rural Health Clinic's ability to support and advise HIV infected mothers,
- training 20 HIV infected women in correct replacement infant feeding practices,
- training 12 Traditional Birth Attendants in safer delivery procedures
- create an HIV infected Mother's Support Group to continue with the message after the project end
- provide a motorcycle for the clinic to allow them to extend outreach visits to the surrounding villages

A total of £ 6,200 would be needed for the project of which **Kaloko** has already raised £ 2,200 and **now seeks £ 4,000 to be able to fully implement the project in 2009.**

Project Background

The current UNAIDS guidelines recommend the avoidance of breast-feeding by HIV infected mothers when replacement feeding is acceptable, feasible, affordable, sustainable and safe. This project attempts to address each of these issues within the community.

In rural Zambia many women infected with HIV deliver babies without professional help. As efforts to prevent peri-natal transmission of HIV expand, traditional birth attendants could play a key role in implementing effective interventions in poor rural settings. It has been shown that it is possible to train traditional birth attendants to perform confidential HIV counselling and encourage testing. With appropriate training, supervision, and support, traditional birth attendants could offer HIV prevention services and help with antiretroviral prophylaxis at delivery.

At the Kaloko Rural Health Clinic in the Copperbelt region of Northern Zambia, which is funded by the Government of Zambia, the nursing staff have received training in the implementation of appropriate Prevention of Mother To Child Transmission activities and have also already

undertaken several HIV support group activities. With the incidence of HIV infections still rising rapidly in the area, the installation of 12 new boreholes supplying clean water and the clinic providing anti-retroviral therapies (ARTs) to all people who are found to be HIV infected, the clinic staff are keen to apply their training.

Due to the increased use of ARTs the risk of intra-uterine transfer is very low and this project aims to reduce infection occurring during birth and through breast-feeding. Staff at the clinic will train 12 Traditional Birth Attendants in safer delivery procedures and 20 HIV infected women of child-bearing age will also receive appropriate training in correct replacement feeding practice. Accepting that there are significant risks for infants in settings with inadequate sanitation, limited access to breast-milk substitutes, or unsafe water the project will seek to address these concerns through training, support groups and follow up visits from qualified clinic staff.

Many women have limited financial resources with which to purchase milk formula and the project, with the help of the local Department of Agriculture's Technician, will start by training 20 HIV infected women and their families on improved agricultural practices (namely the production of soyabeans) which has proven a more commercially viable crop than the traditional maize crop and could thus provide families with the income required to purchase milk formula. Only once the families have the necessary sustainable income to continue to purchase milk formula will the project then move on to the two other training components of replacement feeding for HIV infected mothers and safer delivery procedures for Traditional Birth Attendants.

Budget

1. Training Traditional Birth Attendants and formation of Mothers Support Group £ 250.00
2. Fuel for outreach activities £ 250.00
3. Income Generation training £ 500.00
4. Training in replacement feeding practices £ 600.00

5. Monitoring and Evaluation	£ 600.00
6. Administration / Project Management	£ 1,000.00
7. Motorcycle transport for clinic outreach	£ 3,000.00

TOTAL PROJECT COST	£ 6,200,00

Needs Analysis

The Kaloko Rural Health Centre was opened in 1994. It was initially run by Kaloko Trust and later handed over to the Government. The clinic has three qualified staff (two nurses and one environmental health technologist), two support staff and a security guard. Kaloko Trust now has been complementing the work of the government at the centre. The centre runs its programmes using a yearly budget called the Action Plan. This plan encompasses all the activities the centre undertakes annually and contains six Health Thrusts which act as priorities for the clinic. These are currently: Malaria, HIV/AIDS and STIs, Tuberculosis, Water and Sanitation, Reproductive Health, Child Health.

The Clinic has carried out 720 HIV tests and of those 197 have proven positive with 47 being women of child-bearing age. HIV infection rates for babies are estimated to be about 12% during delivery which can be reduced to around 9% if the mother is on ARTs. 14% of infants can be infected through breastfeeding. With the project being proposed, the availability of free ARTs, appropriate delivery procedures and replacement feeding many children will not become infected, with all the complications to both them and their families that this would mean.

Project Time Frame

The income generation component of the project will follow the agricultural calendar and commence in December 2008 using existing funding. The training component will commence once funding is secured and will run for at least four months.

Project Activities

- Conduct counselling and testing for antenatal mothers
- Conduct maternal referrals when need arises
- Provide access to income generating activities for 20 HIV infected mothers
- Procure cooking demonstration utensils and feeding logistics for 20 HIV infected mothers

- Train 20 HIV positive mothers on infant feeding options
- Train 12 Traditional Birth Attendants in community supervision of HIV infected mothers
- Form one Support Group for HIV infected mothers
- Conduct leadership training on prevention of mother to child transmission of HIV/AIDS.

Project Implementation and Reporting

The project will be implemented by Nurse-in-charge of the Kaloko Rural Health Clinic who will be supported by the Director of Kaloko Trust Zambia who lives and works in the project area. Technical advice and agricultural training will be provided by the Department of Agriculture Technician who also lives locally. The Kaloko UK Director visits Zambia to monitor projects three times per year. Project progress will be regularly reported in the Kaloko Newsletter, which is produced three times per annum, and a full final report will be sent out to all donors with details also included in the Trustees Annual Report.

Project outcomes

1. >10,000 members of 11 local villages will benefit from improved outreach services from the Rural Health
2. pregnant women in 11 villages will benefit from the improved services from 12 trained Traditional Birth Attendants (TBAs) to achieve significant health risk reduction during deliveries which they perform
3. 12 Traditional Birth Attendants (TBAs) will benefit from reduced risk to themselves of being infected by HIV during deliveries
4. 20 families with People Living with AIDS (PLWA) will receive better returns for agricultural produce thus improving their ability to purchase milk formula
5. new-born babies of 20 HIV infected mothers will benefit from reduced risk of being infected by HIV

Kaloko Trust

Kaloko Trust UK was established in 1995 as a UK registered charity (No. 1047622). Our objectives are to promote sustainable rural development in Africa. We do this by working in partnership with local NGOs. Our work has focused on Zambia, where we work principally with a locally registered NGO, Kaloko Trust

Zambia, which has been established for 19 years.

Within Zambia we are presently involved in a comprehensive range of rural community development initiatives, at a grass roots level. Activities include: Agricultural Development, Community-based Natural Resource Management, rural-based Income-Generation, both formal and informal sectors of Education, Primary Health Care and Health Education.

Currently the main focus of activities is at Luansobe, an area of 400 square kilometres about 100 kilometres south of Ndola, in the Copperbelt Province. The local population is about 12,000, the vast majority of whom are subsistence farming families. Single women head 1/3 of local households and approximately 50% of the population are below the age of 18 years, with a very high percentage of these HIV/AIDS orphans.

Kaloko's vision (for the Luansobe community) is one where:

- Every family is able to meet their basic household food requirements
- Every family has access to education, health services and clean water
- Every family has the opportunity and skills to earn a basic income
- Kaloko Trust Zambia is an independent and dynamic local NGO, and is a valued and integral part of the Luansobe community

Kaloko believes in an integrated approach to development and as such we work with communities to address their broad development needs, rather than focussing on isolated themes. Some of our medium term objectives are:

- To increase our support for local agriculture, including developing dry season cultivation for food security and income generation
- To develop local community schools to increase educational opportunities, especially for HIV/AIDS orphans
- To increase health services and access to clean water in more remote areas, particularly focussing on women and children
- To further develop our support for beekeeping as a source of income
- To increase Kaloko Trust Zambia's ability to raise funds independently

Kaloko has a number of broader, longer-term strategic objectives that underpin all our activities and aim to move us towards realising our vision. These are:

- To enhance the Luansobe Community's ability to support itself economically

- To enhance the Luansobe Community organisationally
- To enhance the long-term stability of the Luansobe community
- To enhance the capacity and effectiveness of Kaloko Zambia as an organisation

Our staff consists of a UK Director, who has over 20 years experience running development programmes in Africa, and who now manages the UK operations and supports our partner organisation in Zambia during regular visits to the field projects. An Administrator based in the Brighton Office, who is also supported by a number of volunteers, supports the UK Director. The Director reports to the Board of Trustees in the UK who meet quarterly.

Kaloko has from inception been funded from a range of sources. These include regular sponsorship from individual supporters, funding from small groups and clubs and grant making bodies, both small and large. In the past we have received support from Comic Relief and the National Lottery, and we are used to handling large grants from grant making bodies.

Further details can be accessed on the website : www.kalokotrust.org. A full version of the 2007 Annual Report and Accounts is available on the Charity Commission website www.charity-commission.gov.uk by entering the number 1047622 in the box in the Search the Register of Charities.

Zambia: Country Information¹

- Capital: Lusaka
- Government: democracy
- Population: 11.9 million
- GNI per capita: US \$630
- Life expectancy: 40.6 years
- Area: 752,614 sq km (290,586 sq miles)
- Major languages: English (official), Bemba, Lozi, Nyanja, Tonga
- Major religions: Christianity, indigenous beliefs, Hinduism, Islam
- People: Over 70 ethnic groups largely black Bantu
- Monetary unit: Kwacha (approx 7,000 = £1)
- Main exports: copper, minerals, tobacco
- Children: 45.7% of population under 15
- Poverty: 68% living below the national poverty line



¹ Statistics from the UN 2007 Human Development Report, World Bank Country Report 2007 and UNAIDS Global Report 2006

- HIV statistics: more than 17% (pop aged 5 – 49)
- Orphans: Zambia has the second highest proportion of AIDS orphans in the world (> 700,000)
- 95% of people in rural areas are subsistence farmers

According to the United Nations, Zambia is ranked 165 out of 177 countries on the Human Development Index². 64% of the population live on less than \$1 a day and 87% live on less than \$2 a day. For some time United Nations indicators for eradicating hunger, achieving universal primary education and reducing child mortality have been in decline. A past legacy of economic mismanagement, debt and disease are said to have contributed to the country's poor economic status today. Politically, Zambia gained independence in 1964, switching from a colonial government into an era of one-party rule lasting 27 years. A multi-party system emerged in the early 1990s and more recently the economic situation has begun to improve.

At independence, Zambia had one of the highest per capita incomes in sub-Saharan Africa. It had large deposits of minerals, a good climate, plenty of agricultural land, and wonderful game reserves. Zambia was encouraged to concentrate on the production and export of copper and it became one of Africa's most industrialised and urbanised countries. Initially the newfound wealth from copper paid for extensive education and health programmes. But following the oil crisis in the 1970s, the price of copper fell dramatically and the price of oil rose. Zambia was forced to turn to the IMF³ and the World Bank for assistance. So began some thirty years of Bank and Fund intervention in the Zambian economy with a period of increasing foreign debt, economic collapse and social crisis. During this time Zambia's debts rose from US\$800 million to almost US\$6 billion. Current monies owed by the Zambian government total US\$3.3 billion.

Since 1991, to qualify for debt relief, Zambia has been forced to implement economic reforms such as privatisation, trade liberalisation, subsidy cuts and public sector wage freezes. And yet, in the same period and despite these actions, Zambia has had the worst economic performance of any African country that has not suffered from conflict.

Its economy declined by 1.7% a year in the 1990s, and by 2003 Zambia had received only 5% of the debt service reduction committed to it. Between 1993 and 1996, Zambia spent four times more on debt servicing than it did on education. The government raised school fees as a result and primary school enrolments fell with almost 600,000 children not attending school, the majority girls. More recently the Zambian government reversed its stand on school fees and access to primary school is now free. However, many schools lack adequate classroom space, qualified staff and appropriate teaching materials and still rely on contributions from parents and other charitable sources.

For poor people in rural areas the consequence of these economic difficulties has been a steady decline in access to such basic rights as sufficient food, clean water, health services and education: 46% of the population are undernourished; 10% of children do not live to see their 5th birthday; only 60% of children go to school; and life expectancy has fallen to 40 years. Against this backdrop of extreme poverty, Zambia now faces yet another crisis: HIV/AIDS. Approximately one in six people are HIV positive and AIDS is now considered the biggest threat to Zambia's struggle for development. It is killing an entire generation, and Zambia now has the second highest number of orphans in the world .

Zambia's climate can be split into three periods. From December to March it is hot and wet, with regular and heavy downpours. The average rainfall at the project site is about 1,000mm a year. From April to August it is dry and cool and then from about September it starts to get progressively hotter until the rains start again. About 70% of Zambia consists of what is termed Miombo woodland. This is a mixture of grassland dotted with trees and shrubs. However, less than 10% of the country is used for agricultural production.

² The HDI provides a composite measure of three dimensions of human development: living a long and healthy life (measured by life expectancy), being educated (measured by adult literacy and enrolment at the primary, secondary and tertiary level) and having a decent standard of living (measured by purchasing power parity and income).

³ International Monetary Fund