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Zambia Integrated Systems Strengthening Program

Inception Report for Clinical Care Specialists

November 2010

This publication was produced for review by the United States Agency for International Development. It was prepared by Zambia Integrated Systems Strengthening Program.

Recommended Citation: Zambia Integrated Systems Strengthening Program. November 2010. *Inception Report for Clinical Care Specialists*. Bethesda, MD: Zambia Integrated Systems Strengthening Program, Abt Associates Inc.

The Zambia Integrated Systems Strengthening Program is a technical assistance program to support the Government of Zambia. The Zambia Integrated Systems Strengthening Program is managed by Abt Associates Inc. in collaboration with Akros Research Inc., American College of Nurse-Midwives, Banyan Global, Johns Hopkins Bloomberg School of Public Health-Center for Communication Programs, Liverpool School of Tropical Medicine, and Planned Parenthood Association of Zambia. The project is funded by the United States Agency for International Development (USAID), under contract GHH-I-00-07-00003. Order No. GHS-I-11-07-00003-00.

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Inception Report for Clinical Care Specialists

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Abbreviations/Acronyms

AIDS	Acquired Immune-Deficiency Syndrome
ART	Anti-Retroviral Therapy
CCS	Clinical Care Specialist
CD4	Cluster of differentiation 4
CDE	Classified Daily Employees
CFR	Case Fatality Rate
C-IMCI	Community IMCI
DHMT	District Health Management Team
DHO	District Health Office
EHT	Environmental Health Technician
EID	Early Infant Diagnosis
EmONC	Emergency Obstetric and Newborn Care
FP	Family Planning
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSSP	Health Services and Systems Program
IMCI	Integrated Management of Childhood Illnesses
ITN	Insecticide Treated Net
IUCD	Intra-Uterine Contraceptive Device
MOH	Ministry of Health
PA	Performance Assessment
PCP	Pneumocystis Carrini Pneumonia
PICT	Provider Initiated Counseling and Test
PMTCT	Prevention of Mother to Child Transmission
RDT	Rapid Diagnostic Test
STI	Sexually Transmitted Infection
TB	Tuberculosis
TSS	Technical Support Supervision
ZISSP	Zambia Integrated Services Systems Program

I. Introduction

The core of the Ministry of Health's (MOH) vision for health care in Zambia is access to cost effective quality health care as close to the family as possible. Under the Health Services and Systems Program (HSSP), the project that preceded the Zambia Integrated Systems Strengthening Program (ZISSP), Abt Associates began seconding Clinical Care Specialists (CCSs) to the Provincial Health Offices. CCSs are physicians appointed to help improve and expand clinical services. The CCSs help organize and strengthen case management and service delivery at the provincial level. However, their work also extends "down" from that level through the district level, all the way to remote health clinics. The CCSs have employed various innovative approaches in their work, which include using principles of mentorship and the creation of clinical care teams (CCTs) to assure quality of services. CCSs took the lead in the expansion of the mobile Anti-retroviral therapy (ART) outreach approach to deliver HIV treatment and other services, and build capacity in remote health facilities in all nine provinces of Zambia. Although their primary focus under HSSP was Human Immunodeficiency Virus/Acquired Immune-Deficiency Syndrome (HIV/AIDS), CCSs were also authorized to work on interrelated health issues including malaria, child health, family planning (FP), and emergency obstetric and newborn care (EmONC) in the provinces.

While significant strides were made to increase access to health care under HSSP, much remained to be done to address the quality of care when the program ended. To build on the gains, broaden the focus of the CCSs to integrate and address quality of care, ZISSP has again seconded nine CCSs to the provincial health offices. These CCSs will provide clinical care support to HIV/AIDS, Malaria, EmONC, FP and Child Health services. The team will spearhead the institutionalization of Quality Improvement programs at provincial and district levels. In collaboration with the Community Health Coordinators, also seconded to the provincial health offices, existing community structures for participation in HIV/AIDS, malaria, maternal and child health services in 27 districts will be strengthened.

The CCSs will also collaborate with the nine Management Specialists, seconded to the provinces to strengthen the management and leadership skills at provincial and district level of program officers

2. Purpose of Report

As an initial step, the CCSs conducted a gap analysis, in order to identify existing gaps in the clinical care functions at provincial and district level. The analysis was conducted in six provinces and the assumption was that the findings would be similar in the other three provinces (Copperbelt, North Western and Southern provinces) not represented at the time of data collection. CCSs for the three provinces had not been recruited at the time of the data collection. The results of the analysis will form the basis for developing strategies to address identified problems and to develop appropriate work plans.

3. Methodology

The CCSs reviewed previous performance assessment (PA) reports, technical support reports, minutes of the technical committee meetings, the sector advisory group reports, Health Management Information System (HMIS) reports and annual action plans for the years 2009 and 2010. Key informant interviews were conducted with selected program officers at provincial and district level. In addition, observations were made during the routine PA conducted in September and October 2010. The four CCSs who worked under HSSP also used their experiences in the previous project to identify the gaps

at all levels of service delivery. However, to eliminate bias, this information was compared with the information gathered through interviews with the MOH CCSs and other program officers at provincial and district level.

4. Summary of Findings

The findings of the gap analysis by major focus area are presented below.

4.1 Quality Improvement

4.1.1 Performance Assessment

The framework for Quality Improvement is generally weak. PAs, which are conducted biannually in the provinces and districts, lacks focus because preparatory meetings are not held to review the previous PA findings. The HMIS has not been used to identify weaker facilities and districts in specific indicators before the PA is carried out. While there was evidence that PA was being conducted in all the provinces assessed, it was observed that there was limited understanding of the PA tools at both provincial and district level. The District Health Management Teams (DHMTs) usually conduct their routine PA in all their health facilities before the provincial assessment is done. It was observed that there was almost always a discrepancy in the findings by the DHMTs, which showed inadequate detail despite the use of exactly the same tool with the province. The reports produced following the PA exercise were not uniform and some findings could not be replicated. This made it difficult for another person to use the report to provide technical support.

4.1.2 Technical Support Supervision

Technical support supervision (TSS) is provided to all districts and health facilities identified with weaknesses during PA. However, the technical support is rarely optimal. It was observed that time assigned for this exercise by the provincial and district teams was inadequate, due to limited human and financial resources. TSS was also found to lack focus and, in some cases, was not relevant to the gaps identified during PA. For example, where case management was found to be poor as reflected by the high case fatality rates (CFRs) in the under-five children, some program officers during technical support would sit with the DHMT, ask questions and tick whether the indicator had improved instead of providing mentorship in case management.

4.1.3 Technical Committees and Performance Review

Technical Committees – convened to assess program performance, analyze root causes and advise on the design of the relevant interventions – met irregularly and, in some provinces, were non functional. Some program managers at the provincial and district levels have limited analytical skills. There was no logical flow of processes to drive the improvement of quality of services and performance of health workers.

4.2 Clinical Case Management

4.2.1 History and Physical Examination of Patients

Case management for malaria and HIV/AIDS was compromised; a critical shortage of clinicians led to high patient workload and non-adherence to standard guidelines and protocols. For example, a Rapid Diagnostic Test (RDT) for malaria requires 15 minutes to read the results, but health workers are unable to spend adequate time to take a comprehensive history or conduct detailed a physical examination of the patient.

4.2.2 ART Service Delivery

Updating clinical records in ART sites is not a standard practice by clinicians as a way of improving the quality of ART services. The annual CD4 monitoring of patients on ART was inconsistent, and in some cases not performed until patients presented with signs of clinical treatment failure, at which point, it becomes too late to offer effective treatment and care. This finding contributes to high mortality in AIDS patients, which should otherwise be avoided.

Adherence to ART is key to program success at all levels. However, it was observed during PA that in some health facilities adherence to ART was below the national standard of 80%. Long distance to ART sites was also reported as one of the major contributors to poor adherence in rural areas.

4.2.3 PMTCT and Pediatric ART Services

Access to ART by pediatric patients has continued to be a major challenge in the nation's efforts to ensure universal access to ART. Currently, fewer than 10% of patients receiving ART in most institutions are pediatric patients. This is due both to inadequate follow-up and monitoring of HIV-exposed babies enrolled in Prevention of Mother to Child Transmission (PMTCT) of HIV during under-five clinics, and to failure to successfully administer Co-trimoxazole prophylaxis to HIV exposed babies, with resultant high CFRs from pneumocystis carrini pneumonia (PCP). Another factor contributing to low pediatric ART uptake is the lack of confidence by the clinicians to manage children on ART. The clinicians have not been adequately trained to manage pediatric ART. Further, the results revealed weak implementation of Early Infant Diagnosis (EID) due to inadequate follow up of HIV-exposed babies enrolled in the PMTCT and Provider Initiated Counseling and Testing (PICT) programs.

4.2.4 Sexually Transmitted Infections

Reference to standard protocols such as the Syndromic Management of Sexually Transmitted Infections (STIs) is not made for specific conditions.

4.2.5 Integrated Management of Childhood Illnesses

The main gap observed in this area was the number of health providers with the knowledge and skills required to manage children using the Integrated Management of Childhood Illnesses (IMCI) approach. Without sufficient numbers of appropriately trained staff throughout the district, children's health will continue to be compromised, even if small numbers of staff are trained to use the IMCI approach. It was

further observed that non-adherence to standard ambulatory treatment protocols was another hindrance to improved child care and this has been attributed to lack of supervision of health workers at the primary health care level.

4.3 Maternal Health

The main gap identified at the facility level is the inadequate number of skilled health providers who are trained to offer quality EmONC. Most health facilities, especially in the rural districts, are manned by unskilled staff such as environmental health technicians (EHTs) and Classified Daily Employees (CDEs). These personnel have not been trained in conducting safe delivery and managing neonatal and maternal resuscitation following delivery. The situation is further worsened by lack of basic equipment to support these services, which results in high neonatal and maternal mortality.

4.4 Child Health and Nutrition

Growth monitoring for the under-five has been hampered by the limited availability of the newly introduced under-five cards, which makes it difficult for health workers to monitor a child's growth pattern, some of whom present with severe malnutrition. CCSs will work through the mentorship teams to provide effective case management, although it has been observed in some districts that such children are readmitted later on due to inadequate food security at household level.

Expanded Program for Immunization coverage, which used to be high in most districts, has dropped over the past two years due to inadequate funding for the DHMTs. The number of health posts for immunizations has been reduced to cover only those that can be funded by the DHMTs. This has contributed to the low immunization coverage by some health centers in the districts. Most children only catch up on their immunization schedule during the bi-annual Child Health Week.

4.5 Pharmacy

Drugs and therapeutics committees, meant to promote rational use of drugs and to guide procurement of drugs and logistics, do not meet regularly and in some districts are non-functional. CCSs will coordinate with pharmacy specialists to strengthen or introduce drugs and therapeutics committees in all health facilities.

5. Selected Functional Areas, Gaps and Proposed Interventions

Functional Area	Gaps	Proposed Interventions
1. Performance Improvement	• Irregular or no technical support following PA of districts. • Irregular or no technical committee meetings that assess performance, analyze performance, and design	• Enhance the understanding of the quality improvement cycle through a capacity building workshop for all provincial and district managers. • Support provinces and districts in planning for, and implementing of,

	interventions that would improve performance of the districts, hence the province. • Quality improvement programs are either inadequate or absent.	PA, technical review meetings and technical support programmes. • A quality improvement package for primary health care will be designed. Defining minimum desired performance standards for primary health care services at various levels of service delivery will be the initial step; interventions that target the gaps noted will be refined and implemented through strengthened clinical care teams. Indicators that track improvement in quality will be defined.
2. Clinical Case Management	• High client–clinical staff ratio (Poor staffing), coupled with poor staff attitude compromises quality of case management • Incomplete case history and examination • Non-adherence to standard ambulatory treatment protocols in tuberculosis (TB), malaria, IMCI and Adult Illnesses • Poorly constituted and passive Clinical Care Teams – poorly run or absolutely no mentorship programs • Nursing care protocols poorly implemented (non use or poorly filled drug charts; no nursing care plans) • Referral system has no functional feedback mechanism • Irregular or absent clinical meetings – no continuous learning programs	• Strengthen human resource retention programs for rural areas • Constitute and strengthen clinical care teams at provincial and district level and institutionalize clinical mentorship programs to strengthen case management. The multidisciplinary clinical care teams must address nursing care and all paramedical aspects of case management. • Institutionalize the process of updating standards of ambulatory care, including TB, STIs, ART, malaria, and disseminating these through routine institutional meetings at provincial, district and facility level. • Strengthen the referral system to include feedback from referral centers, as a way of building capacity at lower levels of care. Strengthen continuous learning through clinical meetings, as a key component of performance improvement

3. HIV/AIDS	• Poor coordination among partners supporting the health sector in HIV/AIDS services • Poor quality of inadequate access to Highly Active Antiretroviral Therapy (HAART) for rural communities; compromised quality of HIV/AIDS care. • Poor linkages between various HIV/AIDS services and programs (TB/ART) • EID continues to elude most facilities; Provider Initiated Testing and Counselling is not practiced in most facilities • Non implementation of revised PMTCT of HIV (monotherapy, with nevirapine, is still practiced in various facilities; poor follow-up for HIV exposed babies) • Inadequate laboratory facilities to support HIV/AIDS services; sample referral mechanisms are weak.	• Revamp and strengthen provincial coordination bodies; this will facilitate leveraging of resources and creation of synergies that will ultimately contribute to improved HIV/AIDS services • Work with the ministry to formulate a comprehensive quality improvement program for HIV/AIDS services, that will include laboratory services • Orientation of staff in TB/HIV collaborative activities • Orient staff in the key interventions of PICT, PMTCT and work with pharmacy and management personnel to ensure the flow of drugs and logistics • Engage districts to strengthen sample referral systems to facilitate early diagnosis and evaluation of patients
4. Malaria	• Malaria diagnosis is based on clinical grounds, and not supported by laboratory evidence (RDTs, Microscopy) • Low insecticide treated nets (ITNs) coverage of pregnant mothers and children under 5 years	• Promote clinical meetings and clinical mentorship to address malaria case management • Work with MOH and other partners to ensure consistent supply of RDTs and ITNs • Work with community coordinators and health education officers to sensitize communities on the use of District Health Offices (DHOs), other partners and communities to improve ITNs to prevent malaria
5. Family Planning	• Erratic supply of FP commodities, such as Depo-Provera • Inadequate numbers of staff trained in implant and Intra-Uterine Contraceptive Device (IUCD) insertion • Incomplete FP registers • Low numbers of new FP acceptors	• Coordinate with FP specialist, MOH and other partners to ensure consistent supply of contraceptives • Coordinate with FP specialist, MOH and other partners to build capacity for frontline health workers in long term FP methods and data management

6. EmONC	• Very few staff trained in Emergency Obstetric and Neonatal Care (EmONC) • Lack of neonatal resuscitation equipment such as resuscitators in delivery rooms and theatres • High still, neonatal and maternal death rates • Still and neonatal deaths not reviewed regularly • Low institutional deliveries and post natal attendance	• Coordinate with the EmONC specialist, MOH and other partners to train frontline staff in EmONC, and to procure equipment • Support district teams to review maternal and still deaths as a way of improving performance
7. Child Health and Nutrition	• Low numbers of staff trained in F-IMCI and in Community IMCI (C-IMCI) • Health workers not managing children according to IMCI guidelines • C-IMCI is limping in all the provinces • Low immunization coverage in remote districts in all the provinces • New under-five cards not available at most centers	• Coordinate with child health specialist, MOH and other partners to train frontline staff in IMCI • Promote the clinical mentoring approach to strength IMCI case management
8. Pharmacy	• Drugs and therapeutics committees hardly meet • No active pharmacovigilance activities reported • Drugs stored under inappropriate conditions in most districts(no or dysfunctional air conditioning) • Irrational use of drugs	• Provide support in revamping drugs and therapeutic committees • Train frontline health workers in pharmacovigilance and rational drug use

6. Conclusion

The gap analysis exercise has enabled ZISSP to focus on high impact interventions that will be implemented in the interlinked areas of HIV/AIDS, malaria, child health and nutrition, EmONC and FP. The CCSs will continue to play a pivotal role in strengthening health care systems at the provincial and district level. The clinical care team approach entails the involvement of the MOH staff, and incorporates sustainability from the onset. Mentorship, PA, technical support, and quality assurance committees will be part of the overall package of quality improvement under ZISSP. CCSs will continue to pursue innovative approaches to support the government in its quest to improve access to quality health services as close as possible to the client.