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# **Inception Reports of ZISSP Personnel Seconded to the MOH and NMCC**

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# **Inception Reports of ZISSP Personnel Seconded to the MOH and NMCC**

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# Contents

Abbreviations/Acronyms.....	ii
1. Introduction.....	1
2. Purpose of the Report.....	1
3. Child Health and Nutrition .....	1
3.1 Description of the MOH Child Health Office .....	2
3.2 Information Sources.....	2
3.3 Description of the Gaps Identified .....	3
3.4 Capacity Building Plan for Child Health and Nutrition .....	5
4. Emergency Obstetric and Newborn Care (EmONC) .....	6
4.1 Description of MOH EmONC Office.....	7
4.2 Information Sources.....	7
4.3 Description of the Gaps Identified .....	8
4.4 Capacity Building Plan for EmONC.....	9
5. Family Planning .....	10
5.1 Description of the MOH Family Planning Office.....	11
5.2 Information Sources.....	11
5.3 Description of the Gaps Identified .....	12
5.4 Capacity Building Plan for Family Planning.....	13
6. Human Resources for Health .....	14
6.1 Description of the Human Resources and Administration Directorate.....	15
6.2 Information Sources.....	15
6.3 Description of the Gaps Identified .....	16
6.4 Capacity Building Plan for Human Resources for Health.....	17
7. Malaria.....	19
7.1 Description of MOH NCMM Office .....	20
7.2 Information Sources.....	20
7.3 Description of the Gaps Identified .....	21
7.4 Capacity Building Plan for Malaria.....	21

## Abbreviations/Acronyms

ACNM	American College of Nurse-Midwives
ANC	Antenatal Aare
ARH	Adolescent Reproductive Health
CBGMP	Community-Based Growth Monitoring Program
CCS	Clinical Care Specialist
CHAZ	Churches Health Association of Zambia
CHN	Child Health and Nutrition
CHW	Community Health Worker
CHWk	Child Health Week
CIDRZ	Centre for Infectious Disease Research in Zambia
CSO	Central Statistical Office
DHMT	District Health Management Team
DLTM	District League Table Model
DMO	District Medical Office
ECZ	Environmental Council of Zambia
EmONC	Emergency Obstetric and Newborn Care
EPI	Expanded Program of Immunization
FHI	Family Health International
FP	Family Planning
GNC	General Nursing Council
HRH	Human Resources for Health
HSSP	Health Systems Strengthening Program
IMCI	Integrated Management of Childhood Illnesses
IRS	Indoor Residual Spraying
IUCD	Intrauterine Contraceptive Device
IYCF	Infant and Young Child Feeding
KFP	Key Family Practice
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal, and Child Health
MOH	Ministry of Health
NBC	Newborn Care
NMCC	National Malaria Control Center
PA	Performance Assessment
PMEC	Payroll Management and Executive Control
PMO	Province Medical Office
PMP	Performance Management Package
PMTCT	Prevention of Mother-To-Child HIV Transmission
PNC	Postnatal Care
PPAZ	Planned Parenthood Association of Zambia
PSMD	Public Service Management Division
RBF	Results Based Financing
RED	Reach Every District
RH	Reproductive Health

RHU	Reproductive Health Unit
SFH	Society for Family Health
TOR	Terms of Reference
TOT	Training of Trainers
TSS	Technical Support Supervision
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fun
UTH	University Teaching Hospital
WHO	World Health Organization
ZDHS	Zambia Demographic Health Survey
ZISSP	Zambia Integrated Systems Strengthening Program

# 1. Introduction

The Zambia Integrated Systems Strengthening Program (ZISSP) builds upon the successes of the Health Services and Systems Program (HSSP) and seeks to improve managerial and technical capacity within central, provincial, and district offices of the Ministry of Health. ZISSP has seconded experienced and skilled staff to the central ministry teams responsible for human resources, family planning, maternal, neonatal, and child health (MNCH), and malaria. The seconded personnel will work to build the capacity of individuals and teams in the ministry, and to develop systems that will improve the productivity of their offices and programs.

As a result of the human resource restructuring process which began in 2004 and has not yet been completed, the Ministry of Health (MOH) operates with an inadequate number of technical staff. This leads to insufficient coordination and support for many programs. The situation may be mitigated in time by the new personnel that have recently joined the MOH. However, in the short run these new staff members require orientation and technical assistance in order to implement work plan activities. The malaria program team is challenged by receiving inadequate resources and technical assistance to scale up and monitor Indoor Residual Spraying (IRS). The MNCH team faces similar constraints to monitoring the implementation of programs.

In part to respond to the critical shortage of health personal, ZISSP will second 10 professional staff in the areas of child health and nutrition, family planning, malaria, human resources, and Emergency Obstetric and Newborn Care (EmONC.) The seconded staff will work within the MOH structure to provide expert advice to improve program planning, design, implementation, monitoring and evaluation.

## 2. Purpose of the Report

This report takes stock of the prevailing situation in the MOH departments where seconded staff have been assigned, identifies gaps, and proposes measures that ZISSP could implement with ministry personnel to improve the current situation. In order to provide a description of the situation in each MOH department to which ZISSP staff members have been seconded, the inception report provides a brief assessment and action plan by program area.

## 3. Child Health and Nutrition

Malaria, respiratory infection, diarrhea, malnutrition, anemia, and neonatal causes are responsible for most child deaths in Zambia. HIV/AIDS has also rapidly become a significant cause of childhood deaths. Some gains have been recorded in terms of child health and nutrition. The neonatal mortality rate has decreased from 37 to 34 per 1,000 live births. The infant mortality rate has fallen from 95 to 70 per 1,000 live births, while the under-five mortality rate has also decreased from 168 to 119 per 1,000 live births. (Zambia Demographic and Health Survey (ZDHS) 2001/2 and 2007).

**Expanded Program on Immunization:** Zambia has recorded some immunization successes, with full immunization coverage standing at 81 percent, according to HMIS in 2008. However, a review of district immunization performance reveals coverage rates as low as 50 percent. The Reach Every District (RED) strategy has been scaled up to 72 districts. The implementation of the RED strategy improved the coverage of child health interventions through community involvement. However, varying degrees of success with RED and general program implementation mean that there are still coverage gaps. Sustaining the benefits the RED strategy will require community-level capacity building and improvements in support systems.

**Facility and Community IMCI:** According to the 2009 Health Facility Survey report, 64 percent of the districts have attained a saturation level of 60 - 80 percent of facility health workers trained in clinical IMCI. Although the essential drug kit for health centers is supplied regularly, maintaining adequate drug supplies continues to be difficult. In addition, facilities are challenged by implementing the HIV component of IMCI, often receive insufficient supervision, and do not always have effective referral systems. Community IMCI has been introduced to 72 districts in which CHWs have been promoting the six key family practice (KFPs) and should, over time, promote the 16 KFPs advised by WHO.

**Nutrition:** The malnutrition rates in Zambia are high. According to the 2007 Zambia Health Demographic Survey, 45 percent of children show evidence of stunting, 5 percent are wasted, and 28 percent are underweight. To address these issues, Zambia is initiating programs for community-based growth monitoring and promotion. ZISSP will seek to strengthen the integration of CBGMP and IYCF practices and identify other community approaches for improved nutrition outcomes.

### 3.1 Description of the MOH Child Health Office

The child health unit in the MOH reports to the Directorate of Public Health and Research.

- It is coordinated by the Child Health Specialist, who is assisted by one IMCI Chief Technical Officer, two Chief EPI Officers, and one Chief Cold Chain Officer.
- Four additional technical officers assist in the implementation of the unit's activities, although they have not received offer letters of appointment.
- The presence of both appointed and un-appointed staff poses challenges in work assignments and commitment to documentation of activities and completion of reports.
- ZISSP fills in the gap of supporting the Child Health Specialist to build teamwork while staff wait for final decisions with respect to the MOH/HR plan.
- The nutrition department is staffed by one nutritionist.

The information and data used for completion of this report came from a desk review of relevant documents and interviews/group discussions with individuals that assist the child health office with planning, implementation, and evaluation of key child health interventions. The table below lists the information sources.

### 3.2 Information Sources

Document name	Source	Planning information	Implementation information	Evaluation information	Key issues listed in the document
CHN work plan	MOH	x	x		<ul style="list-style-type: none"> <li>• 2010 activities</li> <li>• GRZ Budgets and partners</li> </ul>
Nutrition work plan	MOH	x	x		<ul style="list-style-type: none"> <li>• 2010 activities</li> <li>• GRZ Budgets and partners</li> </ul>

Document name	Source	Planning information	Implementation information	Evaluation information	Key issues listed in the document
Nov 2009 Child Health Week report	MOH	x	x	x	<ul style="list-style-type: none"> <li>• Successes of CHWk</li> <li>• Coverage by district resources</li> <li>• Challenges and recommendations</li> </ul>
Revised EPI vaccination manual	MOH	x	x	x	<ul style="list-style-type: none"> <li>• Immunization in practice guidelines</li> <li>• Cold chain management</li> <li>• Injection safety and waste management</li> </ul>
IMCI orientation guidelines	MOH	x	x	x	<ul style="list-style-type: none"> <li>• Components of IMCI</li> <li>• Planning for IMCI training</li> <li>• Monitoring health worker performance</li> <li>• IMCI essential drugs</li> <li>• Key IMCI indicators</li> </ul>
Community register	MOH	x	x	x	<ul style="list-style-type: none"> <li>• Demographic information</li> <li>• Key child health interventions</li> </ul>

### Individuals and organizations interviewed

Name	Organization	Position
Dr. Helen Mutambo	WHO	EPI Team leader
Dr. Ngoma Ngawa	UNICEF	EPI Program officer
Maureen Mubanga	CARE International	Program manager
Ruth Siandi	UNICEF	Nutritional program officer

### 3.3 Description of the Gaps Identified

The ZISSP CHN Advisor conducted a gap assessment in order to identify and address bottlenecks and challenges. The desk review revealed the gaps and opportunities described below.

**Immunization coverage in target districts:** Although national full immunization coverage stands at 80 percent, review of district specific data reveals coverage as low as 50 percent. The ZISSP CHN advisor will work through ZISSP Community Health Coordinators to support DMO efforts to strengthen RED implementation and community participation. ZISSP will conduct a situation analysis in

27 target districts to examine RED strategy support systems for facilities and communities. ZISSP provincial teams will use assessment findings to work with the MOH, PMOs and DMOs to build district capacity and strengthen community participation and use of community register to improve reporting.

**IMCI situation analysis:** The IMCI training database in the child health unit is incomplete due to lack of data entry staff. The desk review will be incomplete without the entry of this training data. To identify saturation levels in target districts, ZISSP will complete data entry.

**Facility and community IMCI training:** Now all 72 districts have some health workers and community volunteers trained in facility and community IMCI. However, many districts have not yet attained the goal of training saturation levels of 60 to 80 percent among facility staff and the placement of one CHW per 500 households. The ZISSP CHN expert will engage the CH team and may engage the Clinical Care Specialists (CCSs) and the CHCs to support IMCI training to fulfill the saturation requirements.

**Sustaining quality of care for sick children:** Sustaining health worker performance following IMCI training is critical in order to improve quality of care. ZISSP will work with the CH department to develop a strategy for mentorship focused on child health issues at provincial and district level. The strategy may leverage the provincial-level ZISSP CCSs and CHCs to strengthen the child health elements of Performance Assessments and Technical Support Supervision (TSS.)

**Orientation of provincial/district teams to IMCI:** TSS visits note that district level comprehensive planning for IMCI and nutrition is inadequate. In addition, new provincial staff members are not yet prepared to support district planning and monitoring. Therefore ZISSP will work with the MOH CH team to assure that the Ministry orients provincial staff to program planning for the three components of IMCI and nutrition.

**Capacity for nutrition implementation:** The shortage of nutritionists at the provincial and district level impedes planning for high-impact nutrition activities. Advocacy to increase the number of nutritionists at these critical levels will hopefully lead to improved staffing. New provincial and district staff will need orientation to the essential nutrition package. ZISSP will support the MOH nutrition team to plan and implement this orientation.

**Capacity for community management of malnutrition:** A number of districts have been implementing very successful growth monitoring and promotion activities; success is limited, however, without integration of appropriate IYCF practices. ZISSP will propose that the MOH nutrition team engage DMOs, with support from ZISSP CHCs, to strengthen planning and integration of CBGMP with IYCF practices

**Improving coverage rates of vitamin A and de-worming.** Eight percent of districts attained at least 80 percent coverage of vitamin A supplementation in the July 2010 integrated measles and CHWk. However, a number of districts' coverage rates remain as low as 50 percent due to systems and coordination challenges. Therefore ZISSP will work with the MOH CH team to engage PMO support for implementation of CHWk. The CH team should engage the PMOs to focus on improving planning, coordination and monitoring for CHWk. The PMOs may use the skills of the CCSs, MSs, and CHCs to support this effort.

**Newborn care implementation:** To reduce newborn and infant mortality rates, Zambia will initiate implementation of improved newborn care practices. The MOH has drafted a newborn care scale-up framework and guidelines. ZISSP will support the CH team to organize the review and updating of the draft scale-up framework and draft guidelines; dissemination of the guidelines; and the training of province and district staff to plan, implement and monitor newborn care practices.

**Child Health and Nutrition Technical Working Group (TWG):** The child health technical working group has proven to be an effective forum for consensus-building process on technical issues.

The TWG improves transparent resources and activity planning by MOH and partners; coordinates development of one partner work plan; and leverages resources and technical assistance. However, the TWG can still be strengthened with technical updates based upon program data which aims to improve strategic planning and appropriate technical assistance to the districts.

### 3.4 Capacity Building Plan for Child Health and Nutrition

Gaps	Activities	Output	Time frame
Improving immunization coverage	RED strategy situation analysis	RED strategy situation analysis report	October – November 2010
	Support printing of existing community register for target districts	2000 community registers printed	November - December 2010
	Orient health workers and CHWs in RED strategy	60 health workers oriented 200 CHWs oriented	November 2010 – June 2011
	Disseminate and document effectiveness of community registers	Tool for RED strategy	November 2010 – June 2011
Facility and community IMCI training	Hire short-term consultant for IMCI training data entry, analysis on agreed critical IMCI indicators	IMCI training database updated	October 2010
	Conduct IMCI situation analysis in target districts	Report generated	2011
	Develop IMCI saturation training plan	Training plan	2011
	Review and print existing IMCI training materials	100 IMCI modules printed	2011
	Support facility IMCI training in 5 districts	5 districts trained in IMCI	2011
	Review and print existing CHW training materials	200 CHW modules printed	2011
	Conduct initial follow up visits following IMCI training	TSS reports generated	2011
	Train CHWs in community IMCI	100 CHWs trained	2011
	Advocate for the	CHW kit decision and	October 2010 – June

<b>Gaps</b>	<b>Activities</b>	<b>Output</b>	<b>Time frame</b>
	purchase of CHW kits through CH/TWG and ICC	funding allocation	2011
	Conduct IMCI orientation for managers at PHO and DHO	PHO and DHO managers oriented on IMCI	October 2010 – June 2011
Sustaining quality of care for sick children	Conduct TSS visits to facilities and community to strengthen PA/TSS	Reports generated	Quarterly
Capacity for nutrition implementation	Conduct TSS visits to strengthen nutrition planning and CHWk activities	Reports generated	Quarterly
	Visits for orientation of provincial/district teams on essential nutrition package	PHO and DHO managers oriented on Essential Nutrition package	2011
	Train facility staff in community management of malnutrition	60 health workers trained	2011
	Train community CHWs in community management of malnutrition	100 CHWs trained	2011
Newborn care implementation	Review and update scale-up framework	NBC scale up document	2011
	Review and update draft NBC guidelines	NBC guidelines updated	2011
	NBC training of supervisors in target districts	NBC Training materials	2011
Strengthening TWGs	Review TORs to strengthen TWGs	TORs revised	January 2011

#### **4. Emergency Obstetric and Newborn Care (EmONC)**

After five years, the EmONC program under HSSP/MOH came to an end in July 2010. Zambia has seen an improvement in the Maternal Mortality ratio (MMR) according to the Zambia Demographic Health Survey from 729 per 100,000 live births in 2002 to 591 per 100,000 live births in 2007. This reduction has been achieved through a number of interventions implemented by the MOH, including the provision

of EmONC, focused antenatal care, strengthening the prevention of mother-to-child HIV transmission (PMTCT) and family planning.

The EmONC program has trained 308 health personnel, and 45 districts have EmONC sites in 166 health facilities. Other achievements include establishment of two national training sites, and training of 15 national trainers and five master trainers. The MOH, with the help of the donor community, proposes to make EmONC facilities fully functional by procuring EmONC facility-level equipment, improving water reticulation systems, installing solar panels for electricity supply, and retaining health workers.

ZISSP will support the MOH in its efforts to scale-up EmONC services in 27 selected districts over the next four years. A gap assessment is essential to identify and address bottlenecks and challenges before commencing EmONC activities. A desk review has been conducted and a number of gaps have been identified.

#### 4.1 Description of MOH EmONC Office

ZISSP has seconded an EmONC Specialist to the MOH. He will be stationed in the Reproductive Health Unit (RHU). The RHU is under the directorate of Public Health and Research. The Deputy Director – Reproductive and Child Health heads the Unit and supervises the following technical support staff: the Reproductive Health Specialist, the PMTCT Specialist, Safe Motherhood Officer, Reproductive Health Officer for Health Promotion, and the Adolescent Health and Family Planning Specialist. The EmONC Specialist will report to the Deputy Director.

#### 4.2 Information Sources

The information and data used for the completion of this report was obtained from review of documents and interviews/discussions with the individuals listed. The following table highlights relevant documents used in the literature review for this assessment.

Document name	Source	Planning information	Implementation information	Evaluation information	Key issues listed in the document
EmONC TWG minutes	MOH	x	x	x	<ul style="list-style-type: none"> <li>• EmONC curriculum</li> <li>• EmONC training</li> </ul>
EmONC reports	MOH	x	x	x	<ul style="list-style-type: none"> <li>• Human resource</li> <li>• Equipment</li> <li>• TSS reports</li> <li>• Indicators</li> <li>• EmONC gaps</li> </ul>
EmONC handover notes	Dr. Carol Phiri	x	x	x	<ul style="list-style-type: none"> <li>• EmONC health facilities</li> <li>• Trainers</li> <li>• EmONC gaps</li> </ul>
Progress	MOH/			x	<ul style="list-style-type: none"> <li>• Indicators</li> </ul>

Assessment Tool; MPoA SRHR Jan 2010	Dr. Mbewe				
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### Individuals interviewed

Name	Organization	Position
Dr. Rueben Mbewe	MOH	Deputy Director – Public Health and Research
Dr. Carol Phiri	HSSP/MOH (2008-2010)	EmONC Specialist
Dr. Mary Nambao	MOH	Reproductive Health Specialist
Ms. Ruth Bweupe	MOH	Adolescent and Family Planning Specialist

### 4.3 Description of the Gaps Identified

A desk review has been conducted and the following are gaps which have been identified.

**National trainers:** The number of trainers is now fewer than 10. As ZISSP plans to scale up EmONC training in 27 target districts, there is need to increase the number of national trainers in readiness for the training planned for 2011.

**National training sites:** Currently there are 2 national training sites for EmONC; University Teaching Hospital and Ndola Central Hospital. Two additional training sites need to be established. Kitwe Central Hospital, Kabwe General Hospital, Livingstone General Hospital, and Chipata General Hospital were proposed in the EmONC TWG as possible training sites. ZISSP can assist the MOH by identifying the two most suitable sites. To achieve economy of effort, portions of this assessment can be performed during the EmONC site and equipment needs assessment in 6 of the 27 targeted districts (No 1.1.3.2.a).

**EmONC curriculum:** The curriculum was drafted and pre-tested in the last four trainings conducted under HSSP. The curriculum requires editing and printing. There is need to hire a consultant to edit the curriculum. UNICEF will offer financial support for the printing of 500 copies.

**Training equipment for EmONC:** With only one set of training models for EmONC, housed at the School of Midwifery at UTH, there is need to purchase more EmONC training equipment prior to the commencement of training in 27 target districts. WHO will offer financial support towards the purchase of training equipment. The EmONC Specialist will liaise with Jhpiego, WHO and MOH, in order to identify equipment specifications and plan for purchase through the Procurement Unit at MOH.

**EmONC Technical Working Group (TWG):** The TWG has not met in a long time. To make the most progress in this area, the EmONC TWG should be re-initiated with new terms of reference and the membership should be reviewed. It is expected that the EmONC TWG can meet on a monthly basis with ZISSP serving as secretariat.

**EmONC post-training follow-up TSS:** TSS visits for Luapula and Eastern provinces have not yet been conducted, although training was conducted in April 2010. The EmONC Specialist will support program mentorship at the provincial and district levels through coordinated efforts with the CCSs. It

might be useful to develop mentorship guidelines at provincial level, with the CCSs taking lead in ensuring that TSS visits are conducted six weeks post-training.

**Office space at MOH:** With the critical shortage of office space at the MOH, it will be difficult for the EmONC Specialist to obtain office space there. Therefore, there is need for continuous lobbying for office space through the office of the Deputy Director – Public Health at MOH.

#### 4.4 Capacity Building Plan for EmONC

Gap	Activity	Output	Timeframe
Insufficient number of national trainers	Select national trainers using established criteria, orient to curriculum  Hold TOT for 20 participants at UTH  Evaluate for proficiency and certify as trainers	20 national trainers trained	January – March 2011
Insufficient number of national training sites	Conduct needs assessment at Kitwe Central Hospital, Chipata GH, Kabwe GH and Livingstone GH	2 additional training sites identified	1– 31 December 2010
EmONC curriculum editing and printing	Hire consultant to edit the curriculum  Print curriculum (WHO to fund)	500 copies of the EmONC curriculum printed	1 October – 15 November 2010  1– 15 December 2010
Purchase of EmONC training equipment (models)	Initiate inventory and develop specification for procurement of training models	EmONC training equipment purchased	October 2010 – February 2011
EmONC TWG	Hold meetings	EmONC TWG TOR and membership drafted  Monthly meetings held	September 2010 – June 2011
TSS	Conduct TSS in Luapula and Eastern provinces  Work with the CCS team to develop mentorship guidelines at provincial level for strengthening TSS	TSS report generated  Mentorship guidelines generated	3 Oct – 9 Oct 2010
Office space for EmONC Specialist	Lobby for space with Dr Rueben Mbewe	Office space acquired	1– 31 December 2010
EmONC site and	Review tools used for site	Tool for site	October – November

<b>Gap</b>	<b>Activity</b>	<b>Output</b>	<b>Timeframe</b>
needs assessment in 6 of 27 target districts	assessments, evaluate efficacy and develop or adapt tools (STTA)	assessment	2010
	Evaluate and adapt/develop tools used for training needs assessment	Tool for training needs assessment	October – November 2010
ZISSP work plan 2011	Participate in ZISSP work plan meeting	ZISSP work plan for 2011	November 2010
Develop comprehensive EmONC training plan for target districts	Conduct selection criteria for training in target districts and develop a training plan	EmONC training plan for target districts	October 2010 – February 2011
Provide support to strengthen postnatal care based on current best practices	Work with child health team to start planning a community-based assessment tool that would incorporate ANC/PNC access and utilization from a community standpoint (review knowledge, beliefs and behavior regarding pregnancy, delivery and postpartum care seeking behavior) – STTA (ACNM)	Tool for postnatal assessment	March – April 2011
	Develop and pretest postnatal assessment tool		April – June 2011

## 5. Family Planning

The Program will continue to build on the achievements of HSSP in family planning. This inception report contains a description of start-up activities, gaps identified, and interventions that will be carried out to address the identified gaps and a detailed work plan for the first year. Adolescent RH is now a separate technical area which was initially part of the FP technical area. The ARH Specialist is based at ZISSP central office. The FP Specialist will however work closely with the ARH Specialist and provide technical support to the ARH Specialist on issues related to Family Planning.

The FP Specialist reported for work at ZISSP on 3<sup>rd</sup> August 2010. The FP Specialist will strengthen the ability of the MOH at the national level to plan, manage, supervise and evaluate delivery of health services nationwide.

The ZISSP focus areas for family planning include the following:

- Improved strategic and operational capacity of the MOH to plan, oversee, and evaluate FP services.
- Increased availability and use of quality FP services and information in target districts.

- Effective integration of FP with ARH, HIV/AIDS and MNCH services and increased male involvement in FP.

The external partners will include WHO, UNFPA, UNICEF, MOH & PPAZ, Child Fund, FHI, SFH, USAID/JSI DELIVER, CHAZ, GNC of Zambia, CIRDZ, as well as others.

### 5.1 Description of the MOH Family Planning Office

The ZISSP Family Planning Specialist seconded to the MOH will be stationed within the Directorate of Public Health and Research under the RH unit. The Directorate is headed by a Director of Public Health and Research and has 4 deputies.

**Structure:** The Reproductive and Child Health Unit is headed by the Deputy Director of Reproductive and Child Health, who supervises a total of 10 staff (Chief Prevention of Mother to Child Transmission Officer, Child Health Specialist, Chief EPI Officer, Chief FP/Adolescent Officer, Chief IMCI Officer, Chief Safe Motherhood Officer, Cold Chain Officer and Logistician.

**Work flow:** The ZISSP FP Specialist's counterpart is the Chief FP/Adolescent Officer who reports to the Deputy Director of Reproductive and Child Health. The FP Specialist also reports directly to Deputy Director of Reproductive and Child Health. The ZISSP work plan will be derived from the MOH work plan.

### 5.2 Information Sources

Information and data for the completion of this report was obtained from a literature review of relevant documents and discussions with individuals as summarized in the following tables.

Document name	Source	Planning information	Evaluation information	Key issues listed in the document
ZDHS	CSO	x	x	Fertility is high and increasing in rural areas; fewer than 1% of married women use IUCD and Implant
FP TWG minutes	MOH	x	x	<ul style="list-style-type: none"> <li>• Logistic management issues – stock outs</li> <li>• Inadequate supervision</li> <li>• Lack of integration of FP with other services</li> </ul>
HSSP end of project report	ZISSP	x	x	<ul style="list-style-type: none"> <li>• Inadequate capacity to use logistics and procurement system at Provincial and District level</li> <li>• Shortage of staff at central and facility level hindering rapid scale up and provision of quality services</li> </ul>
National Health Strategic Plan 2011 - 2015	MOH	x	x	HIMIS not fully functional in hospitals, private facility and community

## Individuals and organizations interviewed

Name	Organization	Position
Mrs. Ruth Bweupe	MOH	FP/ARH Officer
Dr. Sarai Malumo	UNFPA	National Program Officer
Mrs. Patricia Kamanga	WHO	National Professional Officer

### 5.3 Description of the Gaps Identified

A desk review of documents and interviews with key partners revealed the following gaps in FP service provision and program management.

- According to the 2007 ZDHS, fertility is high and increasing in rural areas. The Total Fertility Rate is at 7.5; use of modern methods is low overall at 26.5 percent without LAM; and fewer than one percent of married women use IUCD and Implant.
- The gaps noted in the FP service provision and accessibility includes contraceptive logistic management at central level and in public health institutions.
- Poor flow of information on FP at all levels of health care system to increase access to family planning services.
- Low skills development on long-term methods
- Poor linkage with other programs limits integration of FP with other service delivery opportunities
- Lack of integration of FP service with other services, e.g., HIV/AIDS, adolescent health and MNCH.
- Inadequate capacity to use logistics and procurement system at the provincial and district levels.
- Shortage of staff at central and facility level, hindering rapid scale up and provision of quality services.
- Inadequate numbers of trained health providers.
- Competing priorities (Family Planning is not a high priority).
- Health providers lack key knowledge on importance of FP to reduce MMR.
- Stock-out of contraceptive commodities at public facilities.
- Weak logistic management skills among some MOH staff.
- Lack of supervision from central and provincial levels; supervision from district to facility is weak and not prioritized.
- Staff members do not understand data collection tools.
- HMIS not fully functional in hospitals, private facility and community.
- HMIS data not used at the point of collection or compilation like districts to inform programming.
- FP officer at MOH needs to follow up on implementation of plans and commitments for procuring contraceptives by MOH.

- Poor linkages with other programs to ensure contraceptive use

#### **5.4 Capacity Building Plan for Family Planning**

<b>Activity</b>	<b>Output</b>	<b>Time frame</b>
Support 27 districts in finalizing action plans to include expanded quality FP services	27 districts supported	July – August 2011
Review training materials for FP	2 workshops held	October – November 2010
Capacity building of Nurse Tutors and Clinical Instructors in FP	23 Nurse Tutors and Clinical Instructors trained	October – November 2010
Develop needs-based training plan for service providers in facility and community	One plan developed	October – December 2010
Attend and provide technical support to ARH, CHN, CH, HIV/AIDS TWG meetings	Twelve TWG meetings held	Quarterly
Work with 27 DHMTs to identify participants to be trained to foster male involvement	270 Motivators trained	October – November 2010
Support training of CBDs	200 CBDs trained	First and Third Quarter 2011
Support training of Peer Educators	200 Peer Educators trained	First and Third Quarter 2011
Update and orientation of managers at central, provincial levels in new imaging issues in FP	55 managers oriented	First and Second Quarter 2011
Support and facilitate TOT in FP, CBFP and VSC	36 health providers trained	Second quarter 2011
Participate in the provincial quarterly reviews of FP data audit.	9 reviews conducted	Quarterly 2011
Integrating FP information and services with other existing programs – e.g., HIV, child health. Education sector programs such as use of media networks in local language (community radios).	9 workshops held	First Quarter 2011
Developing FP advocacy strategies.	1 workshop held	Second Quarter 2011
Capacity building of Nurse Tutors, Clinical Instructors in FP service provision.	77 Nurse Tutor and Clinical Instructors trained	Third and Fourth Quarter 2011
Support capacity building of health providers in FP service provision.	180 providers trained	Third and Fourth Quarter 2011

Support the training of managers at all levels of MOH in logistic management	36 managers trained	Third and Fourth Quarter 2011
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## 6. Human Resources for Health

Zambia is one of the countries in the region that continues to experience substantial and complex challenges with respect to delivery of health services to its citizens. One of the contributing factors to these challenges is the critical shortage of trained health professionals in the public health sector, which is currently operating at 50 percent of the expected number of health workers on the Ministry of Health's establishment structure. This is exacerbated by high levels of internal and external "brain drain," with the loss of core health cadres to the Zambian private health sector, to other countries within the region, and to developed countries. In addition, there has been an increased attrition rate of health workers due to deaths, retirements and resignations. An additional factor is the imbalance in the distribution of health workers between urban and rural areas which has negatively affected the effective delivery of health service in the rural areas.

All available evidence clearly demonstrates that the shortage of human resources and the increasing attrition of staff are major obstacles to improved health service delivery and the achievement of the health-related Millennium Development Goals in Zambia.

There are currently only just over 800 doctors working in the public sector and there are severe shortages of nurses and other key health staff. Planned interventions are not being implemented because there are insufficient numbers of the required qualified health cadres and service delivery is hampered. The WHO states that the current staff numbers on the establishment would have to increase from 23,176 to 49,360 to achieve the WHO-recommended staff-population ratios.

The crisis is particularly acute in rural areas, where more than 50 percent of rural health centers have only one qualified staff member. Numerous facilities are without any professional staff at all. The poorest provinces, such as the Northern, North Western, Central and Eastern, have the most severe staffing shortages. The situation is compounded by weak administrative and management systems in the public health sector, with high levels of absenteeism.

Building on previous successes of the Zambian HSSP to improve managerial and technical capacity within district and provincial health offices and health care facilities, ZISSP will work to provide and improve managerial and technical capacity of selected areas within the Ministry. The support will include the provision of healthcare-related and human resources capacity building for MOH officers.

ZISSP will lay the foundation for a broad long-term strategy for strengthening human resources approaches and will tackle several major challenges which the Ministry faces:

- The need for improved capacity and tools for human resources planning and development at both the headquarters and provincial levels.
- The need for a comprehensive HRIS with additional modules to better manage its human resources, to enable the building of skills matrices and the generation of HR Management Information Reports with which to improve long-term planning.
- The retention scheme and other attraction systems are urgent measures to address the current crises, although these cannot be sustained without donor funding and planners will need to consider strategies for the longer term.

- The implementation of the performance management systems. The current management systems and incentives do not stimulate optimal performance and productivity and the new Performance Management Package needs to be launched.

Below are the results of the initial assessments undertaken as well as the challenges faced by the Human Resource and Administration Directorate of the MOH in the planning, management, development and supervision required for effective healthcare service delivery. This includes challenges related to the Zambian Health Workers Retention Scheme as an urgent measure to address the HR crisis and sustainability of the same scheme, the need for an expanded HRIS to better manage its Human Resources, improved capacity and tools for HR management at the national, provincial and district levels and the need to operationalize the currently available Performance Management Package system and therefore ensure stimulation of optimal performance and productivity.

### **6.1 Description of the Human Resources and Administration Directorate**

According to the approved organizational structure, the HRA Directorate at MOH Headquarters currently stands at 83 staff members, of whom a total number of 15 hold professional HR positions, with the remainder in the administration and logistics positions. The Directorate is headed by the Director of HRA, who is assisted by two Deputy Directors—one in charge of administration and logistics; the other, human resources. There are three units under this Directorate: Human Resources Management, Human Resources Development, and Administration and Logistics.

The deputy Director HR is assisted by 3 officers in charge of management, staff development and planning functions: a Chief Human Resource Development Officer, who is supervises two Senior Human Resource Management Officers (SHRMOs), one in charge of management and one in charge of planning. The SHRMOs oversee one Senior Human Resource Management Officer responsible for management duties.

The administration and logistics section has a total of 67 staff members, all under the Assistant Director Administration and Logistics; their positions range from that of Controller, Plant and Equipment, immediately under the Assistant Director, to the lowest position of Driver.

At the provincial and district levels, the Human Resource Directorate is supported by at least three to four HR positions at the province and one to three positions of Human Resource Management officers in some districts.

### **6.2 Information Sources**

The information and data used for the completion of this report was obtained from a literature review of relevant documents and inputs provided by the existing Technical Advisor: Human Resources & Administration. The TA: HRA has been working within the Ministry on a long-term technical assistance project since 2007, through the Swedish International Development Agency (SIDA).

The following table highlights relevant documents used in the literature review for this assessment.

<b>Document name</b>	<b>Source</b>	<b>Planning information</b>	<b>Implementation information</b>	<b>Evaluation information</b>	<b>Key issues listed in the document</b>
Zambia Health Workers Retention	MOH, DHRA	x	x	x	<ul style="list-style-type: none"> <li>▪ Objectives</li> <li>▪ Health district categories</li> <li>▪ Targets for scale up</li> </ul>

Scheme Guidelines					<ul style="list-style-type: none"> <li>▪ Table of benefits</li> </ul>
Minutes of the Human Resource Technical Working Group meeting held on Tuesday 8/06/2010	MOH, DHRA	x	x	x	<ul style="list-style-type: none"> <li>▪ Planning</li> <li>▪ Recruitment</li> <li>▪ Pre- and Post-service training</li> <li>▪ Retention</li> </ul>
Human Resources for Health Strategic Plan 2006 – 2010	MOH	x	x	x	<ul style="list-style-type: none"> <li>▪ Guiding principles</li> <li>▪ Objectives</li> <li>▪ Implementation</li> <li>▪ M&amp;E</li> </ul>
HRIS Report : July 2009	MOH	x	x	x	<ul style="list-style-type: none"> <li>▪ Status</li> <li>▪ Advantages of SAP software</li> <li>▪ Cost implications</li> <li>▪ HRIS Project Team</li> </ul>
Concept paper on the Bonding System among Health Care Workers	MOH	x	x	x	<ul style="list-style-type: none"> <li>▪ Objectives</li> <li>▪ Recommendations on bonding system</li> </ul>
Approved organizational structures and staffing levels for MOH. 26-Jan-07	MOH	x	x	x	<ul style="list-style-type: none"> <li>▪ Departments, sections &amp; units</li> <li>▪ Staff numbers</li> <li>▪ Positions</li> </ul>

### **6.3 Description of the Gaps Identified**

#### **Gaps in the Zambia Health Workers Retention Scheme**

- The lack of qualified medical personnel in designated health facilities in rural and “hard to reach” areas in provinces and districts because of inadequate and poor working conditions, inadequate education and training systems, lack of housing and poor living conditions, and poor performance management throughout the public health sector
- Lack of sufficient funds to support the scheme, which has mainly been supported by Cooperating Partners, and lack of sustainability for the future of the scheme
- Lack of capacity at the provincial and district Levels to support decentralized management of the scheme
- Lack of performance monitoring and evaluation systems of the ZHWRS to assess its effectiveness in terms of service delivery

- HR staffing crisis due to high staff turnover in critical cadres such as Doctors, Nurses, Laboratory Technologists and Pharmacists, because these cadres are attracted to larger and better-equipped urban health facilities

### **Gaps in the HRIS**

- The need to upgrade the HRIS and open more modules. The Government runs a SAP-based program called Human Capital Management and has purchased the end-user license fees for one module, namely the Payroll Management and Executive Control (PMEC). The Ministry is currently under-utilizing the PMEC module as many HRIS and statistical reports can be generated. The SAP software suite has several other modules which can be opened through the procurement of additional modules, such as ‘talent management’ and ‘scenario planning’ capability for future proposed human resources strategy and planning purposes. Additional modules will need to be procured from SAP Southern Africa and configured to the existing PMEC module, and end-user license fees will need to be procured through the GRZ’s Public Service Management Division (PSMD).

### **Gaps in Human Resource Management and planning**

- Lack of strategy to attract and retain operational staff in the public health sector
- Lack of proactive planning of HR issues by the HR & A Directorate
- Lack of funding for the MOH to recruit the required numbers of clinical cadres

### **Gaps in performance management systems**

- The performance management system developed by the Public Service Management Division is called the Performance Management Package’ (PMP) and has not yet been launched at the Ministry of Health due, in the main, to funding constraints. Therefore there is no operational performance management system within the Ministry. It is essential that the PMP is launched so that there is an available tool and system with which to monitor and raise productivity and performance standards and hence service delivery in the public health sector.

### **Other Gaps**

- Long and protracted procedures for processing applications for much-needed local and foreign health workers in the recruitment process
- Extremely lengthy delays in processing appointment letters by Cabinet Office’s PSMD which acts as a further de-motivating factor leading to frustrations and the high attrition rate within the public health sector
- Lack of researched evidence-based information to guide organizational development interventions for effective HR management and functioning.

## **6.4 Capacity Building Plan for Human Resources for Health**

<b>Gap</b>	<b>Activity</b>	<b>Output</b>	<b>Time Frame</b>
Capacity of the ZHWRS	Hold a meeting to establish the status of the ZHWRS	Report on the status of the ZHWRS	1 – 15 October 2010

<b>Gap</b>	<b>Activity</b>	<b>Output</b>	<b>Time Frame</b>
	Undertake capacity building & implement monitoring systems for ZHWRS at provinces and Districts.	Number of HR staff trained	1 October – 30 December 2010
	Work with MOH Consultant to evaluate the ZHWRS	Evaluation report of the ZHWRS	1 - 30 December 2010
	Support the MOH retain 119 key persons in the ZISSP supported Districts	119 key personnel retained on the ZHWRS	1 October 2010 - 30 June 2011
Strengthening the HRIS	Conduct a meeting to establish user requirements for the HRIS and review of the same	Minutes of meeting	1 October 2010 – March 2011
	Conduct meeting to discuss HRIS options to improve ZHWRS including linkage to PMEC	Minutes of meeting Report on the upgrade of the HRIS. (Deliverable due January 15)	20 October – 30 December 2010
	Develop data gathering guidelines for information required for the HRIS	Data Guidelines	30 December 2010
	Identify trainer of the HRIS and Implement user training.	Number of staff trained	1 December 2010 – 30 March 2011
	Work with relevant supervisors to monitor data gathering and inputting into the data base.	Monthly progress reports	30 March 2010 – 30 June 2011
	Work with MOH & Partners to monitor production of reports from the system	Reports produced	30 March 2010 – 30 June 2011
Performance Management System	Conduct training for 2 Directorates at MOH HQ on the use of the Performance management and assessment system as pilot	Number of staff trained	1 – 30 November 2010
	Piloting of performance assessments for the 2 Directorates at HQ	Completed performance assessment tools and reports	1 to 30 December 2010
	Undertake evaluation from the implementation.	Evaluation report	1 – 15 January 2011

Gap	Activity	Output	Time Frame
	Begin development of a roll out strategy to additional Directorates and 2 provinces.	Strategic plan for roll-out (Deliverable due on January 15)	1 Jan – 10 January 2011
Capacity for human resource management & planning	Analyze the existing training needs assessment for HR staff in Provinces and 9 selected Districts, assess National Training Plan	Training manuals collated and timeline set for training	15-30 October 2010 for first Capacity Building training program
	Implement training according to identified needs	Number of staff trained	1 January 2011 to have revised training plan in place
Strengthened recruitment procedures and processes	Consult with relevant players in streamlining the procedures and processes	Progress reports	All quarters

## 7. Malaria

According to 2008 national HMIS data, malaria is still the number one cause of mortality and morbidity in Zambia, although a positive trend in reduced morbidity and mortality has been observed over the past three years. Indoor Residual Spraying (IRS) is one of the core interventions adopted by the MOH to prevent malaria.

The Ministry of Health through the National Malaria Control Centre (NMCC) began implementing IRS in 2003, with a mandate to cover 15 districts. In 2005, through HSSP, USAID started supporting IRS activities in the 15 districts. During the 2007 spray season, HSSP supported districts through NMCC to spray 657,695 household structures (93.5% of the targeted coverage). As part of a scale up of malaria control efforts to attain the MDG targets by 2010, the Ministry of Health/NMCC initiated the expansion of the IRS coverage from 15 districts to 36 districts in 2008 and from 36 districts to 54 districts in 2010.

The ZISSP goal is to strengthen the ability of the NMCC to coordinate, oversee and scale up IRS and other malaria intervention, particularly developing sustainable capacity at NMCC for planning, implementation, monitoring and evaluation of national malaria program interventions, namely, case management with artemisinin-based combination therapies (ACT), malaria in pregnancy and IRS. The ZISSP malaria team will focus on the NMCC's expanded IRS program by refining technical tools and guidelines; developing logistic mechanisms, delivering a national and targeted Training of Trainers (TOT) and districts cascade training; institutionalizing routine entomological surveillance and support to the NMCC insectary. ZISSP will also work with NMCC to strengthen M&E for malaria and develop a case surveillance and response system.

This report provides the results of the initial assessment completed by the seconded staff to NMCC and states the challenges faced by the health office with regards to planning, implementation and evaluation of the malaria interventions.

## 7.1 Description of MOH NCMM Office

ZISSP will second six full-time specialists to NMCC: IRS Specialist, IRS Information Systems Specialist, Malaria Entomologist, IRS Logistics Officer; IRS M&E Specialist, Active Case Surveillance Manager and four part-time insectary technicians.

The NMCC is under the directorate of Public Health and Research of the Ministry of Health. The Deputy Director of Public Health and Research heads NMCC and has technical support staff; one IRS principal officer, one Chief Entomologist, one Research and Operations Officer, one M&E Officer, one IEC Officer, and one malaria epidemiologist.

The gap analysis data was collected using desk review and interviews from the officers at the NMCC as shown in the tables below.

## 7.2 Information Sources

Document Name	Source	Planning information	Implementation information	Evaluation information	Key issues listed in the document
National malaria control strategy plan	MOH	x	x	x	Vision, policy and road map for malaria interventions in Zambia
Malaria Indicator Survey (MIS) Report 2008 & 2006	MOH		x	x	<ul style="list-style-type: none"> <li>▪ Information of the survey to measure the progress of the national targets in malaria</li> </ul>
Malaria program review report	MPR External & Internal authors		x	x	<ul style="list-style-type: none"> <li>▪ Successes of malaria program in Zambia</li> <li>▪ Challenges of the malaria program in Zambia</li> </ul>
NMCC 2009 Action plan	MOH/NMCC	x	x	x	<ul style="list-style-type: none"> <li>▪ Indicators</li> <li>▪ Objectives and goals of NMCC</li> <li>▪ Activities</li> </ul>

The following table lists the individuals interviewed for this assessment.

Name	Organization	Position
Dr Mulakwa Kamuliwo	MOH	Deputy Director – Public Health and Research-

		NMCC
Mr. Chadwick Sikaala	MOH	Principal IRS Officer
Mr. Hawela Moonga	MOH	Malaria Diagnostic Officer
Mr. Hamainza Busiku	MOH	Research and Operations Officer

### 7.3 Description of the Gaps Identified

After the interview and the desk review, the following gaps were identified.

**IRS:** IRS operations are highly time-bound and must follow a strict schedule to assure that planning, procurement, training, commodity deliveries, spray operations, and entomological studies occur according to a set calendar. Delays impact spray effectiveness. Adherence to technical guidelines and maintaining high productivity require careful and continuous monitoring and supervision. NMCC has only one officer dedicated to this and this may compromise the quality of the intervention.

**Entomology:** Entomological studies are essential for monitoring and assessing the entomological impact of indoor residual spraying (IRS) by determining the efficacy of residual activity of insecticides on treated surfaces and materials. Entomological investigations for monitoring IRS require a functional insectary capable of producing sufficient numbers of mosquitoes for use in the conduct of insecticide resistance/susceptibility tests. The insectary at the NMCC provided mosquitoes for the insecticide resistance studies. NMCC has no position for insectary technicians and there are no entomologists in the districts. Recently reported resistance to DDT in Ndola, Solwezi and Kabwe calls for strategic resistance management. Therefore, if not properly managed, the extensive use and misuse of insecticide for vector control will compound the resistance problems across the country and eventually run out of alternative insecticide for IRS. Each resistant problem is unique and may require a unique solution. The current human resource and infrastructure base for effective surveillance and monitoring of IRS at national, provincial and district level is not adequate to meet increasing demands. This must be addressed with urgency, through both capacity-building and need-based training at all levels.

**Case management and malaria in pregnancy:** Malaria accounts for 20% of maternal deaths in Zambia. It is also a leading killer for children under five. Malaria has other effects on the pregnant mother, such as anemia and increased chance of HIV transmission from mother to child. The negative effects of malaria in pregnancy are also passed on to the unborn child, resulting in intra-uterine fetal death, low birth weight, and miscarriages. Therefore prompt and effective diagnosis and treatment of malaria is important in the prevention and control of the disease. NMCC has no dedicated officer who oversees this component, as the one who used to be responsible is the current Deputy Director. Although a position has been developed for a medical officer responsible for mentorship and training of health workers in malaria case management at NMCC, it remains unfilled.

**Geographical Information System (GIS):** GIS is an important activity for enumeration of structures in the districts. This enables the NMCC to plan effectively during the spray season. Usually the information gathered is not fully utilized because there is no person at NMCC responsible for this.

**Storage facilities:** An initial assessment has shown that very few facilities meet the minimum standards set by ECZ for storage of IRS chemicals. There is need to work with MOH to maintain these facilities so that they meet the standards.

### 7.4 Capacity Building Plan for Malaria

Gap	Activity	Output	Timeframe
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<b>Gap</b>	<b>Activity</b>	<b>Output</b>	<b>Timeframe</b>
Inadequate HR at NMCC for IRS	<ul style="list-style-type: none"> <li>▪ Continue supporting NMCC to conduct TOTs at provincial and district levels so that capacity is built at that level.</li> </ul>	10 master trainers trained annually	Every year at the start of the spray season and during the spray season
Insufficient number of entomologists at NMCC and the districts	<ul style="list-style-type: none"> <li>▪ Work with the University of Zambia to conduct yearly refresher courses on entomology</li> <li>▪ Mentor Environmental Health staff in the districts to conduct basic entomological work</li> </ul>	15 Environmental Health staff trained in basic entomology annually	Annually Quarterly as required
Inadequate HR at NMCC for case management	<ul style="list-style-type: none"> <li>▪ NMCC to fill in the position of case management officer</li> <li>▪ Support NMCC in mentoring clinicians in malaria case management through ZISSP CCSs</li> </ul>	<ul style="list-style-type: none"> <li>▪ 90 clinicians trained and mentored annually</li> </ul>	2011 (outside ZISSP control)  Annually
No GIS personnel at NMCC	<ul style="list-style-type: none"> <li>▪ Build capacity at district level in GIS</li> </ul>	<ul style="list-style-type: none"> <li>▪ 60 trained in GIS annually</li> </ul>	Annually
IRS storage facilities not meeting Environmental Council of Zambia (ECZ) standards	<ul style="list-style-type: none"> <li>▪ Support districts to maintain IRS storage facilities to ECZ set standards</li> <li>▪ Encourage the districts to comply with ECZ standards</li> </ul>	<ul style="list-style-type: none"> <li>▪ 6 districts supported annually</li> <li>▪ All district storage facilities certified by ECZ</li> </ul>	Annually