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ZAMBIA INTEGRATED SYSTEMS STRENGTHENING PROGRAM

QUARTERLY REPORT JANUARY- MARCH 2012

April 2012

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

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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, and John 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).

Recommended Citation: Zambia Integrated Systems Strengthening Program: January – December 2011. Zambia Integrated Systems Strengthening Program Grants Annual Program Statement for 2011. Bethesda, MD: Zambia Integrated Systems Strengthening Program, Abt Associates Inc.



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QUARTERLY REPORT

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ACRONYMS

AID	Active Infection Detection
AIDS	Acquired Immunodeficiency Syndrome
AMSTL	Active Management of the Third Stage of Labor
APS	Annual Program Statement
BCC	Behavioral Change Communication
CBGMP	Community Based Growth Monitoring and Promotion
CCS	Clinical Care Specialists
CCT	Clinical Care Team
CDC	Center for Diseases Control
CEDPA	Centre for Development and Population Activities
CHA	Community Health Assistant
CHC	Community Health Coordinator
CHV	Community Health Volunteer
CHW	Community Health Worker
CO	Contracting Officer
CP	Cooperating Partner
DEMS	Direct Entry Midwifery Schools
DHO	District Health Office
DHIO	District Health Information Officer
DHS	District Health Survey
DIM	District Integrated Meeting
DMO	District Medical Officer
DQA	Data Quality Audit
EGPAF	Elizabeth Glazer Pediatric AIDS Foundation
EHT	Environmental Health Technicians
EHO	Environmental Health Officers
EMMP	Environmental Mitigation and Monitoring Plan
EmONC	Emergency Obstetric and Newborn Care
FANC	Focused Antenatal Care
F&A	Finance and Administration
FP	Family Planning
GIS	Geographical Information System
GPS	Global Positioning System
GRZ	Government of Zambia
GST	Grant Support Team
HBLSS	Home-based Life Saving Skills
HCAC	Health Center Advisory Committee
HCM	Human Capital Management
HIA	Health Information Aggregation

HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HRM	Human Resource Management
HS2020	Health Systems 2020
HSSP	Health Services and Systems Program
IBP	Implementing Best Practices
IMaD	Improving Malaria Diagnostics
IMCI	Integrated Management of Childhood Illnesses
IMPAC	Integrated Management of Pregnancy and Child Birth
IPT	Intermittent Preventive Therapy
IRMTWG	National Insecticide Resistance Management Technical Working Group
ITN	Insecticide Treated Net
IRS	Indoor Residual Spraying
ISMS	International Site Management System
IVM	Integrated Vector Management
IYCF	Infant and Young Child Feeding
JAR	Joint Annual Review
JSI	John Snow Incorporated
LLIN	Long Lasting Insecticidal Net
LTFP	Long Term Family Planning
MBB	Marginal Budgeting for Bottlenecks
MIS	Malaria Indicator Survey
MLA	Management and Leadership Academy
M&E	Monitoring and Evaluation
MIS	Malaria Indicator Survey
MOH	Ministry of Health
MOP	Malaria Operational Plan
MOU	Memorandum of Understanding
MNCH	Maternal Newborn and Child Health
MS	Management Specialist
MSL	Medical Stores Limited
MTC	Malaria Transmission Consortium
NHC	Neighborhood Health Committee
NHSP	National Health Strategic Plan
NIPA	National Institute for Public Administration
NMCC	National Malaria Control Centre
NFNC	National Food and Nutrition Commission
NHA	National Health Accounts
NTWG	Nutrition Technical Working Group
PA	Performance Assessment
PDA	Personal Digital Assistant
PHO	Provincial Health Office
PIM	Provincial Integrated Meeting

PIR	Performance Indicator Reference
PPH	Postpartum Hemorrhage
PRI	Performance Indicator Reference
PMEC	Payroll Management Establishment Control
PMEP	Performance Monitoring and Evaluation Plan
PMI	President's Malaria Initiative
PMP	Performance Management Package
PMTCT	Prevention-of-Mother-to-Child Transmission (of HIV)
PPAZ	Planned Parenthood Association of Zambia
PPP	Public Private Partnership
PSMD	Public Service Management Division
QI	Quality Improvement
RCQH	Regional Center for Quality Health Care
RDL	Radio Distance Learning
RDT	Rapid Diagnostic Tests
RED	Reach Every Child in Every District
RFA	Request for Applications
RH	Reproductive Health
SMAG	Safe Motherhood Action Group
SMGL	Saving Mothers Giving Life
TSS	Technical Support Services
UNZA	University of Zambia
USAID	United States Agency for International Development
UTH	University Teaching Hospital
VSI	Ventures Strategies Innovation
WHO	World Health Organization
ZDHS	Zambia Demographic Health Survey
ZHWRS	Zambia Health Worker Retention Scheme
ZISSP	Zambia Integrated Systems Strengthening Program
ZPCT	Zambia Prevention, Care and Treatment

EXECUTIVE SUMMARY

This report provides an account of program implementation under the Zambia Integrated Systems Strengthening Program (ZISSP) during the period January to March, 2012 and highlights achievements made through close collaboration with the Zambian Ministry of Health (MOH). The report also notes challenges experienced, as well as the plans for the next quarter.

In support of the central MOH program ZISSP:

- Disbursed a total of ZMK 689,795,221.50 to the MOH to reimburse the Zambia Health Worker Retention Scheme (ZHWRS) basket for 119 health care workers during the period October to December 2011. ZISSP also worked with the Human Resources Directorate to update the ZHWRS monthly payroll and prepared contracts, invoices for re-imburement and bonus payments for scheme members.
- Collaborated with selected family planning trainers to conduct the second post training follow-up of nurse tutors and clinical instructors in North-Western Province covering three districts (Solwezi, Kasempa and Ikelenge).
- Established the terms of reference to guide the development of the Adolescent Health communication strategy.
- Identified and trained 22 health care workers from six provinces to be new national Emergency Obstetric and Newborn Care (EmONC) trainers as a way of ensuring that adequate trainers were available to implement the EmONC training plan.
- Supported the training of 30 community health promoters (18 females and 12 males) from Chiengi in community infant and young child feeding (IYCF) and growth monitoring and promotion (GMP) which is 11% of the total number of trainings planned in on these topics for 2012.

In the clinical care technical area, highlights from the quarter:

- Hired a consultant to develop the MOH Quality Improvement National Operational Guidelines and review the existing training package for health workers at all levels.
- Supported 25 district Clinical Care Teams (CCTs) from four provinces (Central, Copperbelt, Southern and Western) during the district CCT monthly mentoring planning meetings.
- Trained 53 multi-disciplinary clinical mentors in two provinces (North-Western and Southern) to address gaps in the CCTs.
- Mentored 215 health workers (56% of whom were males and 44% were females) in five provinces in the following areas: general clinical case management, focused antenatal care (FANC), ART, management of labor, integrated management of childhood illness (IMCI), malaria case management, information management, and pharmaceutical and logistical information management.

ZISPP, through its Management Specialist component:

- Funded the printing and distribution of five sets of planning tools for the provincial statutory boards, hospitals, training institutions, health center/post and community level.
- Trained 115 managers in six planned workshops under the first Management Leadership Academy (MLA) modules since the MLA program was introduced in the country, the focus of which was on problem definition and basic principles of supply chain management.
- Supported two provinces (Copperbelt and Southern) to conduct data quality audit meetings for program officers from provincial, district and hospital levels where a total of 65 program officers were trained.

Under its malaria component, ZISSP:

- Continued to support the supervision and monitoring of indoor residual spraying (IRS) activities by working through the provincial health teams which were trained in the fourth quarter of 2011 to conduct the final phase of the implementation of IRS activities in line with the National Malaria Control Center (NMCC) guideline.
- Trained five new clinics in active infection detection (AID) through a two day classroom and field-based training bringing the total AID clinics in Lusaka to 10 (five were funded through the District Health Office and the other five through ZISSP), at the request of the MOH.

The ZISSP community team:

- Selected focus communities based on a set criteria in line with the indicator that tracks ZISSP activity implementation in target communities.
- Pretested radio programs one and two of the radio distance learning program, in Kafue and Chongwe, with Safe Motherhood Action Groups (SMAGs) and revisions were made based on feedback.
- Conducted a bidder's meeting, appraised potential grantees, oriented the national grant support teams and issued a call for proposals to invite organizations to provide training and mentorship to grantees to enable them to implement their activities in line with USAID standard guidelines.

Key highlights under the Monitoring and Evaluation Unit included redefining and realigning of the Performance Monitoring and Evaluation Plan (PMEP) indicators under program monitoring.

The Capacity Building Unit worked closely with the Clinical Care Specialists and a consultant to finalize the facilitator's and participant's manuals and tools for mentorship use in facilities. The unit also continued to assist all technical teams to improve their success stories through the knowledge management component.

Key challenges to project implementation included delays in filling key positions, for example, the Clinical Care Specialists in two provinces. Also, the shifting of dates for certain events by the MOH meant that certain activities such as the National Health Accounts survey could not be implemented.

I. INTRODUCTION

This report presents ZISSP's performance progress during the period January 1st to December 31, 2011. The report outlines the key program achievements and the challenges experienced during implementation.

ZISSP seeks to increase the use of high-impact health services through a health systems strengthening approach, following the World Health Organization's concept of six building blocks that comprise the system. ZISSP works to strengthen the individual building blocks and the linkages between the blocks. The intention is to improve all the health system building blocks and manage their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes.

ZISSP focuses primarily on service delivery, the health workforce, information, and leadership and governance. The project seeks to address the drivers of health system performance: inputs, policies and regulations, organizational structure, and the behavior of health system actors.

In addition, ZISSP works at all levels of the health system, the national (Ministry of Health [MOH] – Central Office), provincial, district and community, to build capacity to deliver high impact health services and to improve the use of health services.

I.1 PROGRAM OBJECTIVES

ZISSP's overarching goal is to work with the MOH to nurture sustained improvements in the management of the health system while also increasing the utilization of high-impact health services.

I.2 TECHNICAL AREAS

ZISSP focuses on HIV/AIDS, malaria, family planning and maternal health, newborn and child health and nutrition. The program strengthens policies, resource management and service delivery systems across these interrelated public health programs. As a result of ZISSP interventions, more families and individuals in selected districts in Zambia are expected to utilize the services and receive the information required for them to attain and maintain good health.

I.3 ORGANIZATION OF ZISSP ACTIVITIES

ZISSP organizes its activities under the following four tasks:

- Task 1:** Strengthen the ability of the MOH at the national level to plan, manage, supervise and evaluate delivery of health services nationwide.
- Task 2:** Improve management and technical skills of health providers and managers in provinces and districts to increase the quality and use of health services within target districts.
- Task 3:** Improve community involvement in the provision and utilization of health services in targeted areas.
- Task 4:** Ensure that service delivery and other activities are effectively integrated at all appropriate levels in the health system through joint planning and in-kind activities with partners and appropriate public private partnerships (PPP).

I.4 STRATEGIC APPROACH

ZISSP provides technical support and capacity building to the MOH to enable the achievement of its program results. To achieve results under each task, ZISSP has adopted the following five main strategies:

- Use a whole-system approach to remove obstacles and strengthen the delivery and utilization of essential services.
- Build Zambian capacity as the foundation for sustainability.
- Increase impact through partner engagement and integration.
- Plan using the “bottom-up” approach in order to ensure relevance and participation.
- Ensure gender integration.

I.5 THE ZISSP TEAM

ZISSP is led by Abt Associates Inc. which works in partnership with Akros Research, the American College of Nurse Midwives (ACNM), Banyan Global, Broad Reach Institute for Training and Education (BRITE), the Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs (CCP), Liverpool School of Tropical Medicine (LSTM), and the Planned Parenthood Association of Zambia (PPAZ).

2. TASK ONE: SUPPORT FOR THE CENTRAL MINISTRY

2.1 HUMAN RESOURCES FOR HEALTH

2.1.1 ZAMBIA HEALTH WORKER RETENTION SCHEME

ZISSP works with the MOH and other partners to improve administrative and financial management of the Zambia Health Workers Retention Scheme (ZHWRS). The current scheme requires assistance for sufficient management and uptake of available retention posts. ZISSP supports the retention allowances for 119 workers (27 medical officers, 80 nurses, and 12 clinical officers) in the project's 27 target districts. During this reporting period, ZISSP disbursed a total of ZMK 689,795, 221.50 to the MOH to reimburse the ZHWRS basket for the 119 health care workers for the period October to December, 2011. In addition, ZISSP worked with the Human Resources Directorate to update the ZHWRS payroll on a monthly basis, attend to various queries by scheme members and prepare contracts, invoices for re-imburement and bonus payments for scheme members.

Delays in information dissemination on staff movements (retirements, death, transfer and study leave, etc.) were identified as a major challenge making it difficult to account for individuals in the scheme. In response to this challenge, ZISSP has included conducting a routine audit of the retention scheme in the 2012 work plan that will be undertaken yearly to ensure that the staff on the retention scheme is in their places. In March 2012, ZISSP initiated audit visits to Mukonchi and St Paul's rural health centers in Central Province. The audit revealed inconsistent payments of the scheme allowances and non-availability of pay slips for those on the scheme. ZISSP provided on-site mentorship on the challenges identified and also distributed the ZHWRS guidelines and forms to the Human Resources Management Officer.

2.1.2 SUPPORT NATIONAL LEVEL PLANNING, IMPLEMENTATION AND EVALUATION FOR HUMAN RESOURCES FOR HEALTH

The MOH is in the process of cleaning up the data on the Payroll Management, Establishment Control (PMEC) system to ensure that the system is able to generate accurate reports for management decisions. As a follow up to the PMEC data clean-up workshop that was held in December 2011, ZISSP funded a second PMEC data clean-up workshop in January 2012. Two teams comprising human resources and accounting staff were constituted by the MOH to work with provincial human resources officers to investigate and interpret the employment status of every employee in the respective provinces. The first team, which was led by staff from Public Service Management Division (PSMD), focused on investigating and updating the PMEC system from the time it was established in 2010 to date. The team was also tasked to identify positions from the old MOH structure for possible integration into

the new one. The second team of human resources management staff focused on cases of staff with locked salaries, employment status and making appropriate recommendations for decision making. This exercise revealed high levels of negligence at the work place by responsible officers, lack of management capacities and consequently, poor performance. This exercise should contribute to a more efficient PMEC system that will respond to the management needs of MOH.

In February 2012, the MOH, with support from ZISSP, conducted a follow up workshop to implement recommendations made at the two earlier workshops. Actions taken during this workshop included effecting transfer of staff from the old structure to appropriate vacant positions in the new structure. In addition, the ZISSP seconded Human Resources for Health (HRH) Specialist and developed a human resources activity log template for tracking work outputs on a weekly basis. The template was approved by the MOH human resources directorate and has been distributed to provincial health offices to use.

2.1.3 IMPROVE CAPACITY OF THE MINISTRY OF HEALTH TO RECRUIT, DEPLOY AND RETAIN ESSENTIAL HEALTH WORKERS

The MOH is working with both public and private training institutions and partners supporting the health sector to increase its capacity to produce and retain health workers. The Government has demonstrated a strong commitment towards the recruitment of graduates from training institutions by providing the budget funds for net recruitment.

As part of the program's support to the MOH, ZISSP is a member of a technical committee on scaling-up the health workforce for improved health service delivery and outcomes in the country. In January 2012, ZISSP, through the HRH Specialist, supported the holding of a technical committee meeting on scaling up the numbers of the health work force. ZISSP is part of the secretariat of the committee.

2.1.4 HUMAN RESOURCES TECHNICAL WORKING GROUP

The Human Resources Technical Working Group (HRTWG), an advisory body to MOH, includes the following stakeholders: Government of Zambia (GRZ) ministries, cooperating partners and associations and regulatory bodies in the health sector. The March TWG meeting, supported by ZISSP, discussed strategies for implementing the national Scale-Up Plan for increasing the health workforce numbers. The meeting resolved that the HRTWG task group should be restructured and new terms of reference developed. The seconded HRH Specialist for ZISSP drafted the terms of reference which were approved by the MOH. The HRH Specialist also drafted a template to be used by HRTWG subcommittees to provide progress reports quarterly and annually. The template has not yet been approved for use by the MOH.

2.2 FAMILY PLANNING AND ADOLESCENT HEALTH

2.2.1 FAMILY PLANNING TECHNICAL WORKING GROUP

The family planning (FP) TWG meetings are a platform for sharing technical updates and monitoring implementation of the MOH FP work plan by stakeholders. ZISSP supported one scheduled and one

extraordinary TWG meeting in the first quarter. The first meeting was held to discuss the 2012 family planning work plan. The meeting recommended that MOH map partner supported FP activities to determine coverage and gaps in FP service provision before the end of the second quarter of this year. The MOH FP training plan for 2012 was also reviewed, and it was noted that many of the planned trainings in long-term FP (LTFP) and community-based distribution would begin in the second quarter of 2012.

In response to the request by the “Implementing Best Practices” (IBP) World Health organization (WHO) consultant, the MOH with support from ZISSP convened a second TWG meeting to orient and update the members of the technical working group on the IBP Initiative. IBP supports partnerships, documentation of evidence-based implementation of best/effective practices, sharing knowledge, fostering change and scaling up family planning and reproductive health best practices. The focus is on what is working well and using innovative knowledge sharing approaches. Zambia has been chosen as a focus country. Another country implementing the IBP initiative is Senegal. The key partners are USAID, UNFPA, East, Central and Southern African Health Community (ECSA-HC), and WHO. The role of the TWG was explained and includes deliberating the change process, mobilizing resources and providing guidance in fostering change.

2.2.2 TRAINING OF HEALTH CARE WORKERS IN LONG-TERM FAMILY PLANNING

In March 2012, a combined team of FP experts involving staff from ZISSP, MOH and selected FP trainers conducted the second post training follow-up of nurse tutors and clinical instructors in North-Western Province covering three districts (Solwezi, Kasempa and Ikelenge). The team visited three schools of nursing, Mukinge, Kalene and Solwezi, to: assess knowledge and skills retention in providing Jadelle as a family planning method; provide on-the-spot technical support and supervision; assess the data collection and management of FP in general and Jadelle in particular; and re-enforce and solicit for management support of FP services. Only two out of the five trained nurse tutors and clinical instructors were interviewed at the time of the follow up as the other three were out of station. Management at the Provincial Health Office (PHO), Mukinge Mission Hospital and the three nursing schools were all very supportive of the program to train nurses to provide LTFP methods.

ZISSP provided financial and technical support for a quarterly FP supervisory visit to Northern Province. The team visited Mbala, Mpika and Nakonde districts. Chilubi district was not visited due to logistical challenges. It was noted that there is a need to strengthen the involvement and engagement of male partners in FP service provision and integrate provision of FP services with other health services provided. As part of the gender strategy, ZISSP will be working with the MOH to address this in the 2012 planned FP family planning activities.

2.2.3 ADOLESCENT HEALTH COMMUNICATION STRATEGY

Following the development of the Adolescent Health Strategy in 2011, ZISSP collaborated with the MOH to develop terms of reference for an adolescent health communication strategy in the first quarter of

2012. The strategy will enable the MOH and partners to develop innovative approaches to introduce adolescent health messages aimed at influencing teenagers to take more responsible decisions regarding their reproductive health behaviors.

2.2.4 TRAINING OF HEALTH PROVIDERS IN ADOLESCENT HEALTH

One of the reasons for adolescents not accessing health services is attributed to health providers' negative attitude towards them. This attitude is as a result of not understanding the unique physical, emotional and psychological challenges associated with the adolescence stage. ZISSP provided financial and technical support to the MOH to convene a second review of the adolescent reproductive health training manuals to complete the review of the modules and incorporate comments from key stakeholders. The adolescent reproductive health mentorship tool was also reviewed and was circulated to key stakeholders for comments.

ZISSP also continued to provide financial and technical support to the adolescent reproductive health TWG which now includes representation from both the reproductive health (RH) and HIV units at the MOH. This support promotes integration and linkages of sexual reproductive health and rights and HIV in Zambia.

During the quarterly technical support and supervision (TSS) in the Northern and Muchinga Provinces, ZISSP identified four health providers to be trained at the provincial adolescent reproductive health Training of Trainers (TOT) workshop to be conducted in the second quarter of 2012.

2.3 EMERGENCY OBSTETRIC AND NEWBORN CARE

2.3.1 TRAINING OF HEALTH PROVIDERS IN EMERGENCY OBSTETRIC AND NEWBORN CARE

In 2011, ZISSP identified and trained 22 health care workers from six provinces as national Emergency Obstetric and Newborn Care (EmONC) trainers to ensure that adequate trainers were available to implement the EmONC training plan. Following this training, ZISSP worked with the MOH to train 135 health care workers and nurse tutors (59 females and 76 males). The total number of health care workers trained in 2011 exceeded the target of 80 for the year because ZISSP took the opportunity presented to leverage resources with other partners and also responded favorably to the urgent need to train health workers in the districts implementing the "Saving Mothers Giving Life" (SMGL) endeavor.

During this last quarter, ZISSP trained 22 health care workers from 21 health facilities in Kalomo District in EmONC theory, including one district coordinator for the SMGL Endeavour; 17 were females and five were males. ZISSP also provided technical and financial support to the MOH to train 20 health workers selected from 16 health facilities in Lundazi District in EmONC theory (11 were males and nine were females). One of the challenges noted was the non-availability of reference manuals (Integrated Management of Pregnancy and Childbirth [IMPAC] and post-abortion care manuals) which are currently out of stock at the MOH. These EmONC-trained health care workers will be able to identify and

manage emergency maternal and neonatal conditions thus contributing to the reduction of maternal and neonatal morbidity and mortality.

In 2011, MOH with support from partners and ZISSP trained 20 health care workers from Mkushi District in EmONC. ZISSP provided support to the MOH to conduct post-training technical support supervision visits to the 20 EmONC providers in March 2012. The purpose of the technical support supervision was to assess EmONC services being provided by EmONC providers, identify gaps and areas that need mentorship and provide support accordingly. A total of one comprehensive EmONC and nine basic EmONC sites were visited. Overall most providers were found to be applying the EmONC skills acquired during the training. The EmONC trainers conducting the technical support supervision also noted that there is still a need for more staff to be trained in EmONC and for more nurses/midwives to be deployed to the rural health centers in Mkushi. There is also a need for mentorship in the use of partograph for management of labor.

2.3.2 RESPOND TO NATIONAL REPRODUCTIVE HEALTH PRIORITIES

Postpartum hemorrhage (PPH) is one of the major causes of maternal mortality in Zambia, resulting in 25% of all maternal deaths. The use of active management of the third stage of labor (AMSTL) has been institutionalized in Zambia and remains the gold standard to prevent PPH at the facility level. However, institutional delivery remains low at 47% (Zambia Demographic Health Survey [ZDHS] 2007) with more than 50% of women delivering at home. This figure is even higher in rural areas where more than 70% deliver at home.

A recent study in Zambia (2010) which was conducted by Ventures Strategies Innovation (VSI) showed that misoprostol helps reduce PPH at community level, and generally the acceptability by women is very high (90%). Following the dissemination of the pilot study by VSI, the MOH recommended the scale up of misoprostol to PPH. In response, ZISSP supported the MOH in drafting guidelines for the use of misoprostol. In the second quarter ZISSP will hire a local consultant to finalize the misoprostol guidelines.

ZISSP also supported a meeting to review the existing Reproductive Health Policy and incorporate recent data from the ZDHS 2007.

2.3.3 COMMUNITY MOBILIZATION FOR EMERGENCY OBSTETRIC AND NEWBORN CARE

The global partnership for Saving Mothers Giving Life (SMGL) is a United States Government endeavor formulated in 2011 to reduce maternal mortality by 50% over a period of one year in Nyimba, Lundazi, Kalomo and Mansa districts. This goal is expected to reduce maternal and newborn mortality through coordinated work between the MOH and the United States' global health platforms, including ZISSP.

ZISSP has provided funds and technical support to conduct a cascade of SMAG trainings as follows: six day TOT for eight SMAG master trainers (two from each SMGL district), six day training for 20 facility-level SMAG trainers (five from each district) and a five day training for 228 community members. Two consultants from ACNM and the ZISSP EmONC Specialist provided the technical support for the training.

2.3.4 EMERGENCY OBSTETRIC AND NEWBORN CARE TECHNICAL WORKING GROUP

ZISSP supported the MOH to hold an EmONC TWG meeting. A key result was the merging of the EmONC TWG and the Fistula TWG into one TWG called EmONC/Fistula TWG. The meeting discussed the problems related to installation of autoclave machines, i.e., six out of eight sites in Lusaka do not have the right requirements for installation including insufficient space, water and electricity. The members were also informed that DFID may extend equipment purchase to Phase 3.

2.4 CHILD HEALTH

2.4.1 INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES (IMCI)

In 2011, results of the performance assessments in Mbala showed poor case management practices for sick children (2011 quarterly MOH performance assessment reports). In response, in the first quarter of 2012, ZISSP provided technical and financial support to the MOH to undertake a facility Integrated Management of Childhood Illness (IMCI) training for 24 health care workers from Mbala and Chilubi districts. This resulted in 81% saturation level of IMCI trained providers for Chilubi and 65% saturation level for Mbala

ZISSP, in collaboration with CARE International, funded another facility IMCI training for 24 health care workers from Mansa and Kawambwa districts. To date, 18 out of the 29 health facilities in Mansa district have reached IMCI saturation levels of 80% and above. The training will be followed up by mentorship visits to re-enforce and sustain the acquired skills. Among the participants, there were thirteen nurses, five clinical officers, six Environmental Health Technicians (EHTs) (two were females and 24 were males).

2.4.2 EXPANDED PROGRAM ON IMMUNIZATION (EPI)

Utilization of the Reach Every District (RED) strategy principles to strengthen routine immunization and other child health interventions has been in practice in Zambia for five years. In 2011, the MOH in partnership with the World Health Organization, ZISSP and UNICEF conducted a situation analysis. One key result was that most staff had not been trained in immunization service provision in the last three years.

The MOH in collaboration with ZISSP funded a training session on the RED strategy for provincial, district and facility staff in eight districts in Eastern Province (Chama, Lundazi, Mambwe, Chadiza, Chipata, Petauke, Katete, and Nyimba). A total of 25 health care workers were trained and acquired skills to strengthen immunization services. As a result, the districts will be equipped to continue scaling up training of facility staff and community volunteers in the RED strategy.

The Child Health Specialist also provided technical support for preparing the under-15 year olds' measles campaign, which will be conducted in June 2012. The decision to conduct this campaign was reached following an in-depth review of epidemiological data on measles outbreak trends, indicating the existence of large numbers of children not immunized against measles.

2.4.3 CHILD HEALTH WEEK

Child Health Week (CHWk) significantly increases the coverage of primary health services beyond those provided routinely at health facilities throughout the country. These services are mainly targeted at children aged 0 - 59 months and include vitamin A capsule supplementation, growth monitoring and promotion (GMP), immunizations, deworming, management of the sick child and use of insecticide treated net (ITN) as well as pediatric HIV care and support.

ZISSP, through the Child Health Specialist, provided technical assistance to write the report of the November 2011 CHWk and funded the National Food and Nutrition Commission to validate the data included in the narrative report. The November 2011 CHWk campaign was deemed successful in achieving its objectives of high coverage in selected interventions.

2.4.4 STRENGTHENING NUTRITION INTERVENTIONS AND LINKAGES

Between January and March 2012, ZISSP supported the training of 70 health care workers (44 females and 26 males) in Infant and Young Child Feeding (IYCF); this represents 32% coverage of the health care workers IYCF trainings planned for 2012. The health care workers came from 13 districts, Chiengi, Mansa, Nchelenge, Kawambwa, Mbereshi, Nakonde, Mpulungu, Chinsali, Isoka, Mporokoso, Kasama, Luwingu and Lufwanyama.

ZISSP also supported the training of 30 community health promoters (18 females and 12 males) from Chiengi in community - IYCF and GMP, representing 11% coverage of trainings planned for the year 2012. In the second quarter the coverage for training of community health promoters will increase to match that of health care worker trainings. The pre-training assessments showed that the community members had mixed messages on infant feeding and lacked information on IYCF; the post-test assessments (by show of hands) indicated that knowledge and skills were gained.

ZISSP provided support for the training of 26 health care workers from Chiengi, and Mansa in nutrition and HIV counseling.

In Lusaka, a team of nutrition technical personnel from the MOH, National Food and Nutrition Commission and cooperating partners met to review and finalize the nutrition mentorship checklists. The checklists are currently with the MOH awaiting approval prior to wider dissemination. ZISSP provided technical and financial support to train 25 health care workers from nine districts (Solwezi, Mwinilunga, Ikelenge, Masaiti, Luanshya, Chiengi, Mpika, Mbala and Nakonde) as mentors for IYCF and community-based GMP. Health workers and community volunteers from the nine districts had earlier been trained in IYCF and community-based GMP.

2.4.5 REVIEW OF COMMUNITY BASED NUTRITION INTERVENTIONS

Chronic malnutrition in the under-five year age group accounts for 45.4 % stunting in Zambia. A number of organizations are engaged in implementing high impact community nutrition interventions. Despite this, there is little information available on the type of interventions, the coverage and their location or the impact of such interventions at community level, consequently, making it difficult for the MOH to plan or leverage resources. For these reasons ZISSP funded a review of high impact community nutrition interventions between December 2011 and January 2012 with the following conclusions and major recommendations:

- Monitoring of community interventions must be strengthened; indicators are not defined for tracking progress at the implementation level.
- Provision of equipment/supplies and job aids need to be increased: job aides such as counseling cards were often unavailable at the community level. In addition, lack of equipment (Salter scales and weighing bags) impedes application of knowledge acquired as a result of training.
- The national Nutrition Technical Working Group (NTWG) needs strengthening to broaden opportunities for sharing lessons learned in implementing high impact nutrition interventions.
- Since the PD HEARTH depends on community assessments to determine criteria for PD HEARTH implementation, it is important that all organizations seeking to support communities applying this model use the guidelines that have been developed by the National Food and Nutrition Commission.

3. TASK TWO: SUPPORT TO THE PROVINCES AND DISTRICTS

3.1 QUALITY IMPROVEMENT AND CLINICAL CARE

3.1.1 DEVELOPMENT OF QUALITY IMPROVEMENT OPERATIONAL GUIDELINES AND REVIEW OF THE TRAINING PACKAGE

In 2011, ZISSP supported the MOH to develop quality improvement operational guidelines for the sector. ZISSP collaborated with the MOH to harmonize the approach to quality improvement in the health sector by first developing National Quality Improvement Operational Guidelines and reviewing the existing training package for health workers at all levels.

Delay in getting approval to hire a consultant to finalize the documents resulted in the activity not being finalized by December 2011. The consultant was hired in January 2012 and has completed the work and submitted the final products to ZISSP. Training of provincial trainers will start in April 2012. The provincial trainers will then conduct training for health workers at all levels within their respective provinces. This cascade approach and the training of the provincial trainers will establish a system that will allow for rapid scale up of training in a more cost-effective manner.

3.1.2 PARTICIPATION IN THE NATIONAL QUALITY IMPROVEMENT TECHNICAL WORKING GROUP

The ZISSP Quality Improvement (QI) and Clinical Care Team Leaders participated in the QI TWG meeting organized by the MOH, where a variety of topics were discussed: the process of institutionalization of quality improvement, finalization of the Quality Improvement Operational Guidelines and the training package by the consultant hired by ZISSP, funding support for the training of provincial trainers, and the incorporation of QI in the in-service curricula for health workers.

3.1.3 ESTABLISHMENT/REVAMPING OF TECHNICAL COMMITTEES IN THE PROVINCES

One of the recommendations in the recently developed national Quality Improvement Operational Guidelines is establishing technical committees where they do not exist and revamping those that are not performing optimally at the provincial and district levels. These committees will comprise the provincial health program managers, cooperating partners, i.e., Zambia Prevention, Care and Treatment (ZPCTII) project, John Snow Incorporated (JSI) and CARE International, and other stakeholders, and will provide a forum for members to share information on how health programs are being implemented, achievements, and challenges. Partner work plans will be shared and areas of support and collaboration identified. These committees will also assist in designing a system that will contribute to monitoring and evaluating health program performance.

In Central Province, the ZISSP Clinical Care Specialist facilitated the revamping of the provincial technical committee and conducted one quarterly meeting which was done ahead of the finalization of the Quality Improvement National Operational Guidelines. PHO program officers and partners shared information on how they implemented their 2011 fourth quarter activities, the challenges and planned activities for the first quarter of 2012. They also reported that there was poor collaboration among the partners and the PHO in implementing the health program. This had contributed to duplication of efforts and wastage of resources. Some cooperating partners were also implementing activities in health facilities without the involvement of the provincial and district health offices which posed a challenge for sustainability of future activities. The committee tasked the PHO to coordinate activities implemented by all partners.

3.1.4 INSTITUTIONALISATION OF CLINICAL CARE MENTORSHIP IN THE PROVINCES THROUGH ESTABLISHMENT OF CLINICAL CARE TEAMS

In 2011 ZISSP supported the MOH to review and harmonize a decentralized approach to clinical mentoring at the district level by forming multi-disciplinary Clinical Care Teams (CCTs) at the provincial and district levels. These teams are designed to facilitate clinical mentoring and other staff professional development initiatives, including facility-based clinical meetings. ZISSP supported the establishment of multi-disciplinary CCTs in Central, Copperbelt, Northern, North-Western, Southern and Western Provinces. However provinces (Eastern, Luapula and Lusaka) which currently don't have ZISSP seconded Clinical Care Specialists have not made much progress.

Formation of the national multi-disciplinary CCT has been deferred to the second quarter to follow the dissemination of the national clinical mentoring guidelines and training package.

The multidisciplinary CCTs conducted the activities highlighted below during this past quarter.

3.1.4.1 TRAINING OF MULTI-DISCIPLINARY CLINICAL MENTORS

Fifty-three multi-disciplinary clinical mentors were trained in two provinces (North-Western and Southern) to meet the gaps in the CCTs in these provinces. Despite previous investment in training mentors in Southern Province, gaps still existed because the province is quite large and in the case of North-Western Province, there has not been a seconded Clinical Care Specialist since the inception of the ZISSP program.

3.1.4.2 PROVINCIAL CLINICAL CARE TEAM CLINICAL MENTORSHIP EVALUATION MEETINGS

The Central Province provincial CCT held one meeting to review mentorship reports from three district CCTs in the province. This evaluation revealed that some districts CCTs were not responding to the identified needs for mentoring. For instance, there was non-use of partographs in the management of labor, non-adherence to sexually transmitted infection guidelines (wrong treatment regimens and clients not counseled and tested for HIV) and a low proportion of children on ART. Instead of addressing these gaps, these district CCTs concentrated on mentoring in history taking which they are conversant with instead of requesting for technical support from the provincial CCT. In addition Central Province also facilitated an orientation meeting for all provincial health office managers

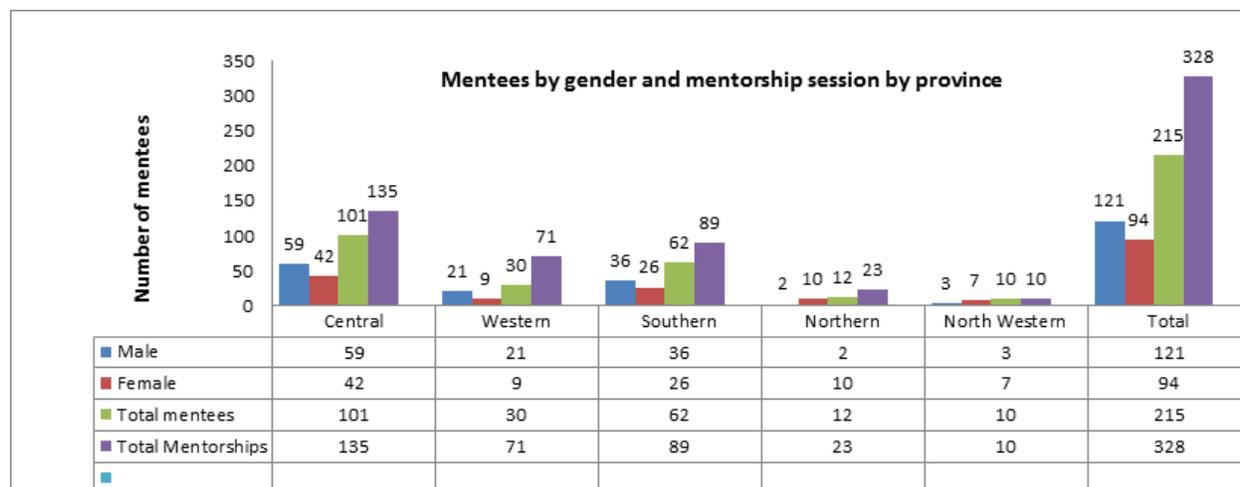
including the provincial medical officer to sensitize them on the importance of the monthly mentorship planning meetings organized by the multi-disciplinary CCTs at provincial and district levels.

3.1.5 PROVINCIAL CLINICAL CARE TEAMS TECHNICAL SUPPORT TO DISTRICT CLINICAL CARE TEAMS

ZISSP supported Central, Copperbelt, Southern and Western Provinces with technical support during the district CCT monthly mentoring planning meetings to review performance data and identify mentorship needs in the subsequent month. In total 25 district CCTs were provided with this support as a way of building the capacity of the district CCTs to identify health service delivery areas, health facilities and health workers that need clinical mentoring. This process helps to ensure cost-effectiveness in implementing the clinical mentorship program in a low resource setting like Zambia. The provincial CCTs also impart knowledge and skills to the district clinical care mentors.

ZISSP supported four of the six district CCTs in Western Province to hold their mentorship planning monthly meetings. In Central Province three of the six district CCTs held two of the three monthly meetings while the others were inconsistent. In Southern Province the 11 district CCTs held only one monthly meeting each during the quarter. In the remaining three provinces (Copperbelt, Northern and North-Western) none of the district CCTs held meetings despite some of them conducting clinical mentoring. Some of the reasons why these meetings were not held as planned include the lack of leadership guidance from the provincial CCTs and poor coordination of activities.

3.1.6 HEALTH WORKERS MENTORED BY GENDER



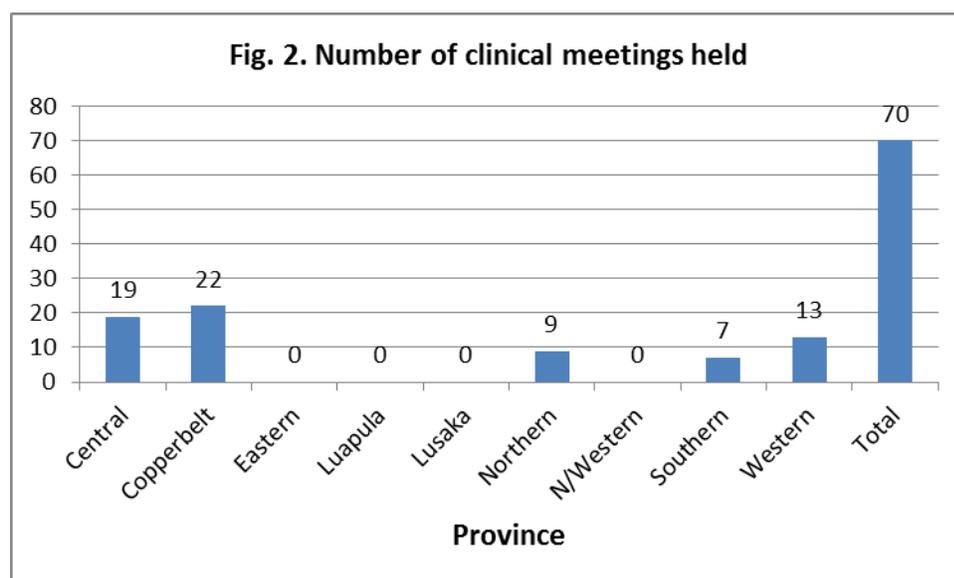
During this quarter, 215 health workers were mentored in 328 mentorship sessions across five provinces (see Figure 1 above), of which 56% were males and 44% were females against a set target of 600 for each quarter. The following areas were covered: general clinical case management, focused antenatal care (FANC), ART, management of labor, IMCI, malaria case management, information management, and pharmaceutical and logistical information management.

Eastern, Luapula and Lusaka Provinces had no ZISSP seconded Clinical Care Specialist to coordinate mentoring of health workers during this past quarter. Although some mentoring had been done in the Copperbelt Province, the change of the reporting requirements by monitoring and evaluation (M&E)

which introduced the need for additional documented evidence from the field to ensure accountability, the Clinical Care Specialist failed to locate the records from the district CCTs. All provinces lost a good number of previously reported mentees.

3.1.7 SUPPORT TO CLINICAL MEETINGS

Holding facility-based clinical meetings is one strategy for continuous staff professional development and also an opportunity to provide updates to health workers on current clinical case management protocols in various fields. Seventy clinical meetings and one clinical symposium were held this past quarter (see Figure 2 below).



Various topics were discussed in all these clinical meetings, particularly the 10 most common causes of morbidity and mortality (including malaria, management of severe malnutrition, TB, pneumonia, management of diarrhea in children), management of hypertension and diabetes (Level 2 hospitals), updates on the 2010 ART and PMTCT guidelines, HIV related opportunistic infections and malignancies, etc. North-Western Province did not report on any clinical meeting while the other three provinces had no ZISSP seconded Clinical Care Specialist to coordinate this activity. Efforts to use existing MOH Clinical Care Specialists have not been effective.

3.1.8 PROVINCIAL QUARTERLY PROGRAM PERFORMANCE REVIEW

Provincial quarterly performance reviews are a QI strategy to evaluate various health program indicator performances with district and provincial health program managers, and cooperating partners in the province. Each district makes a presentation of their profile on selected indicators in HIV, TB, malaria, maternal and child health/nutrition, health care financing and human resources for health for the period under review. This is also accompanied by an analysis of the performance highlighting achievements, challenges and the measures put in place to address the latter. Ideally this should also be conducted with

health facilities within the districts. Because of the cost, ZISSP only funds provincial level performance review meetings. Discussions with the stakeholders revealed that this is a priority activity for the PHO which conducts the provincial and/or district integrated meetings (PIM or DIM) which have not been consistently held due to erratic and inadequate funding. To ensure sustainability, ZISSP is looking at innovative ways of implementing this activity and to make it effective in improving health program performance. During this past quarter, only the Western Province conducted its quarterly review meeting to evaluate health program performance at provincial level, Lewanika General Hospital and the districts in the province from 2009 to 2011. The meeting also served as a forum for partners to share their experiences, achievements, challenges and future plans. Following this meeting, districts devised new strategies on how to improve performance in 2012 and formulated action points for follow up during 2012.

3.1.9 PARTICIPATION IN PERFORMANCE ASSESSMENT

Biannual performance assessment is another performance evaluation strategy for health programs which is conducted by the provinces for selected health facilities in all districts in their respective provinces. ZISSP provides financial support for its entire technical staff seconded to the provinces to participate in this exercise. In the first quarter of 2012 all seven Clinical Care Specialists including the newly recruited Lusaka Clinical Care Specialist participated in this activity.

Prior to conducting the performance assessment, Clinical Care Specialists from Central, Southern and North-Western Provinces facilitated preparatory meetings. These meetings involved reviewing previous performance assessment reports, technical support supervision and other indicator reports from the districts and health facilities which were to be visited for the performance assessment. This enabled the PHO to constitute appropriate performance assessment teams with appropriate representation and identify special areas of focus during the exercise.

The following were the major challenges identified in the clinical areas:

- An inefficient referral system for maternity cases due to lack of transport in Chingola and Monze districts.
- Lack of FANC services due to stock outs of RPR test kits and micro-cuvettes for Hb tests.
- Health facility and community (Neighborhood Health Committees) linkages were nonexistent in the Copperbelt Province contributing to a drop in immunization coverage, ANC and postnatal attendance.
- Clinical meetings and mortality reviews were not held in some health facilities in Copperbelt and Western provinces.
- HMIS and SmartCare were not correlated; SmartCare forms were incomplete; there were stock outs of ART SmartCare stationery in most health facilities in all five provinces.
- Non adherence to ART, STI, malaria and IMCI guidelines.
- Non availability of clinical reference documents at health facilities (ITGs, lack of reference treatment protocols) even at the University Teaching Hospital (UTH).
- At UTH, only 850/3,910 (22%) of eligible HIV positive clients were initiated on ART.

- CD4 monitoring not conducted as scheduled in the guidelines in Monze; cases of clinical and immunological failure identified with no follow up action.
- Non adherence to TB diagnostic guidelines (only nine percent TB patients diagnosed at UTH were based on sputum, 91% were based on chest x-ray).
- Only 82/846 (10%) STI cases at UTH had their contacts treated.
- Mine hospitals in Mufulira were using Fansidar as first line treatment for malaria.

3.2 MANAGEMENT AND LEADERSHIP

3.2.1 DEVELOPING AND BUILDING CONSENSUS ON PLANNING TOOLS AT THE PROVINCIAL HEALTH OFFICE LEVEL

As a final step to the standardization of the MOH planning process at all levels, ZISSP completed the development of planning tools for the provincial statutory boards, hospitals, training institutions, and health center/posts and community level in 2011. Building on this work, ZISSP funded the printing and distribution of five sets of planning tools in the first quarter as follows:

- 500 copies of the Provincial Health Office Planning Tool
- 500 copies of the Statutory Boards Planning Tool
- 500 copies of the Hospital Planning Tool
- 500 copies of Training Institutions Planning Tool
- 2000 copies of the Health Center/Post and Community Planning Tool

These planning tools are aligned with the new planning requirements and therefore will improve planning at MOH and provincial levels, and strengthen the bottom-up approach to planning through improved community engagement. The five sets of planning handbooks will be disseminated during the launch of the 2012 annual planning cycle to respective institutions through the PHOs.

3.2.2 TECHNICAL SUPPORT TO THE MINISTRY OF HEALTH TO CUSTOMIZE THE MARGINAL BUDGETING FOR BOTTLENECKS TOOLKIT TO MEET DISTRICT LEVEL REQUIREMENTS

The MOH decision to roll out the marginal budgeting for bottlenecks (MBB) toolkit during 2012 required that the existing toolkit be reviewed and customized to suit the district level standards of operation. During this past quarter, Health Systems (HS) 2020 in collaboration with ZISSP provided technical support to the MOH by providing consultants to hold consultative meetings with key MOH program officers with a special focus on health planning, HIV/AIDS, ART, malaria, child health and nutrition, maternal health, and TB. The purpose was to reach agreement on the indicators that districts would continue monitoring and that were already part of the MBB toolkit and to confirm the expected performance levels on national targets, removing those which were not relevant. The result would be a simplified district tool. The meetings resulted in a first draft of the customized MBB toolkit to be piloted in two selected provinces, Lusaka and Southern. Plans are underway to train trainers in the tool in May 2012.

3.2.3 SUPPORT TO THE MINISTRY OF HEALTH TO IMPLEMENT THE NATIONAL HEALTH ACCOUNTS SURVEY AND CONDUCT RESOURCE MAPPING IN 27 TARGET DISTRICTS

The National Health Accounts (NHA) survey was scheduled to take place during the first quarter. This was delayed and only started during the last week of March 2012. ZISSP provided financial and technical support to the MOH and the Department of Economics at the University of Zambia to initiate the recruitment and training of data collectors. ZISSP will also fund part of the field activities in the form of transport and fuel costs for the data collectors. ZISSP supported Management Specialists from all the nine provinces who will participate as supervisors. The Management Specialists will also conduct resource mapping in 27 target districts testing the newly developed resource tracking tool to determine its appropriateness as an institutionalization tool. ZISSP will also contribute to the NHA survey by facilitating data analysis through an Abt consultant who will work with the MOH and the University of Zambia. The consultant will help to build the capacity of the Zambian team in conducting the NHA survey. The MOH has already decided to collect data on an annual basis from all the districts using the new tool.

3.2.4 STRENGTHENING MANAGEMENT AND USE OF DATA

ZISSP has continued to provide technical assistance and funding to PHOs and DHOs to assist them in analyzing their data as part of the preparatory work prior to their performance assessment, technical support supervision and planning activities. ZISSP supported Copperbelt and Southern Provinces to conduct data quality audit meetings for program officers from provincial, district and hospital levels. This activity was conducted as preparatory work for the development of provincial statistical bulletins.

A total of 64 program officers were trained in conducting data quality audits (See trainee category in the table below).

Program Officers trained in Data Quality Audits

Staff Category	Trained	Southern	Copperbelt
Senior Health Information Officers	2	1	2
District/hospital Health Information Officers	20	11	9
MCH Coordinators	5		5
Clinical Care Specialists	1		1
Clinical Care Officers	5		5
District Planners	13	12	
Data Associates	15	14	1
Communicable Diseases Specialists	1		1
Provincial Nutritionists	1		
Principal Nutritionist			1
Total	64	38	26

In Kaputa and Mbala districts, ZISSP provided onsite mentoring and coaching to program managers. During this exercise, data collection, collation, and reporting completeness were identified as major challenges in 13 health facilities. Health facility staff also had difficulties in aggregating data for supervised deliveries by trained and skilled personnel. The supervising team provided an onsite orientation and assisted the facility staff to review registers and to complete data entry into the Health Information Aggregation (HIA) tool. This activity resulted in improved reporting completeness for Kaputa District Health Office, going from 78% before the follow up visit to 96% after the visit.

Further technical and financial assistance was provided to Western and Southern Provinces to develop provincial statistical bulletins. Western Province has produced a draft bulletin which is currently undergoing technical review. Southern Province is still writing their document following a successful data review and cleaning exercise. The respective provinces and other health institutions will use the statistical bulletins as reference documents during health services planning and decision making. ZISSP will support development of statistical bulletins in the other provinces in the second quarter.

3.2.5 REVISION OF PERFORMANCE ASSESSMENT TOOLS

The revision of the MOH's performance assessment tools continued during the first quarter. ZISSP provided technical support to the MOH through active participation by the program specialists who ensured that selected program indicators that are in line with the national indicators were adequately addressed in the draft. ZISSP also financed the second round of the review of the performance assessment tools where input was solicited from senior provincial, district and hospital managers. The activity resulted in the development of the first draft tools for all the levels (MOH, provincial, district, hospital and health center). The next step will be for the MOH to share the revised tools with a wider audience to build consensus before completing the revision process. ZISSP has planned to support the consensus building meeting for all stakeholders and will fund a consultant on behalf of the MOH to edit and format the revised tools. The tools will be ready for use by August 2012. The new tools will lead to improved performance assessments and ultimately improved service delivery at all levels of the health care system.

3.2.6 STRENGTHENING PARTNER COLLABORATION AT PROVINCIAL AND DISTRICT LEVEL

ZISSP has continued to provide support to provinces and 27 target districts to hold stakeholder meetings, as part of the government's efforts to strengthen partnerships at all levels and ensure a well-coordinated system for delivery of health services.

Management Specialists worked with the PHOs in Luapula and Northern Provinces to hold stakeholder meetings in each of the provinces. The Luapula Province meeting focused on getting local partner involvement in the performance assessment and technical support supervision in the province and districts as a strategy to increase partner support to health programs. This meeting resulted in the formation of technical working groups based on the partner's area of interest and are expected to participate in performance assessment and technical support supervision and spearhead implementation and monitoring of service delivery in the areas of their support.

In Northern and Muchinga Provinces, the focus was to review the performance of the thirteen districts in 2011, highlighting the achievements, challenges and health priority areas of focus for the first quarter of 2012. Issues identified were poor indicators and report completeness in the provinces which they attributed to institutions not conducting data analysis and review meetings, and lack of ownership of the data. This meeting identified Kaputa and Mbala as the worst performing districts in the area of information management. Subsequently, a technical supportive supervision visit was conducted in the two districts where staff from 13 facilities were trained and mentored in basic information management and how to complete reports.

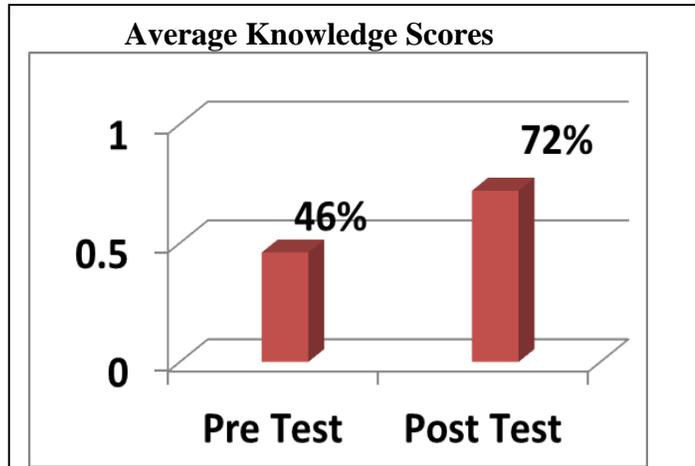
The cooperating partners (CPs) who attended the meeting congratulated ZISSP for organizing the meeting and proposed that CPs should consider funding a whole week meeting so that technical updates and all issues between partners and district offices are dealt with in one meeting instead of each program area inviting participants in a specific function area. ZISSP will continue to encourage other partners to support these meetings that have been very useful, but most importantly to advocate for institutionalization of the meetings.

3.2.7 ROLL OUT MANAGEMENT AND LEADERSHIP ACADEMY TRAININGS BASED ON MLA CURRICULUM AND CASE STUDIES

ZISSP and its sub-contractor BRITE worked with the MOH to conduct six trainings in Western, Eastern and Luapula Provinces, and three ZISSP target districts which included Luangwa, Nyimba and Mansa. A total of 105 managers were trained in the planned workshops, bringing the total to 331 trained in the first Management and Leadership Academy (MLA) modules since the MLA program was introduced in the country. These six workshops marked the end of the trainings with the first modules which focused on problem definition and basic principles of supply chain management. The participants in these cohorts will now move to the next module which will focus on project /program management starting from May this year.

Tracking performance has been one of the activities during the course using score sheets. This process has demonstrated increase in knowledge among trainees after training (See graph below).

Average score -pre and posttest MLA training results



3.2.8 TRAINING OF TRAINERS AND MENTORS FOR THE MANAGEMENT AND LEADERSHIP ACADEMY

A key principle under the MLA approach is that participants should receive short, onsite workshops and then be followed up to reinforce application of skills through comprehensive mentoring and case studies. ZISSP with its sub-contractor BRITE worked with the MOH to agree how mentorship was going to be provided and agreed that the mentorship program be linked to the MOH performance assessment and technical support supervision for sustainability purposes, and that senior managers at all levels of the MOH be trained mentors of the different levels below them.



NIPA Trainer, Michael Sinkala, providing case study mentorship to the Mbala Cohort in March 2012.

In March 2012, training was held for 28 senior mentors from the MOH headquarters, provinces, and hospitals in the first three modules to provide adequate understanding of the process. Participants were also oriented to the MLA concepts of mentorship. The managers should then participate in the various levels of the mentorship programs provided by the MLA throughout the course of the training program.

At district level, mentorship activities were conducted in Northern and Central Provinces using the National Institute for Public

Administration (NIPA) trainers, BRITE team and the hosting Management Specialists. Although both activities were reported to be very successful, there were a few challenges:

- Staff movement that occurs in the districts has the potential to affect their continuation in the program.
- Poor condition of roads affecting the ability to access health facilities, such as Chimika RHC in Central Province.
- Inability to use a specific case study, such as the one for EmONC, due to lack of information available on maternal deaths, for example, at Chimika RHC.

In the second quarter, ZISSP in collaboration with BRITE will initiate trainings on the third module in project/ program management in all the provinces and districts that have received the first trainings. Mentorship programs will continue in the same provinces. ZISSP and BRITE have started developing the next set of modules on Human Resources and Budget and Finance in preparation for the third round of trainings.

3.3 MALARIA

3.3.2 SUPERVISION AND MONITORING OF THE 2011 INDOOR RESIDUAL SPRAYING SEASON

Supervision and monitoring of indoor residual spraying (IRS) activities is an integral component of the National Malaria Control Center (NMCC) guidelines. The guidelines recommend three supervision and monitoring exercises in one spray campaign at the beginning, middle and end of the season. The purpose of this activity is to ensure that the spraying of household structures is conducted in line with the IRS guidelines. At the end of the fourth quarter, 2011, ZISSP funded the provincial health teams in each of the nine provinces and provided technical assistance to supervise and monitor IRS activities in all the 72 districts. During this past quarter, ZISSP worked through the same teams to implement the third exercise in the 72 districts. The major challenge during the 2011 spray season was late funding by the MOH to the districts to cover operational costs. The majority of districts received the funds late and therefore districts implemented IRS in January and February when there were already rains. This resulted in the disruption of the program and many districts recorded a substantial amount of refusals.

3.3.3 COVERAGE OF INDOOR RESIDUAL SPRAYING IN 2011 SPRAY SEASON

In the 2011 IRS spray season, 1,908,869 housing units were targeted for spraying in all the 72 districts by the NMCC. 1,621,794 of the total housing units were sprayed, resulting in 83% national coverage. A total of 1,054,740 housing units were targeted for spraying in the President's Malaria Initiative (PMI) supported districts. Out of these 916,293 were sprayed, resulting in 86% coverage. The total number of people protected nationally was 7,419,708 while in the 35 PMI districts, the number of people protected was 3,809,102. The spray campaign suffered a set back because of late funding to the IRS program. As a result of the delays in the World Bank funding for district IRS operations, there was a delay in starting of the IRS campaign and this significantly affected the coverage. Table 1 shows the number of structures targeted and sprayed with support from PMI in the 2011 IRS season, while Table 2 shows the number of structures targeted and sprayed in the 72 districts.

Table 1: Structures targeted and sprayed with support from PMI in 2011 IRS season

No	District	2011			
		Number of Structures		No. of People Protected	Coverage
		Targeted	Sprayed		
1.	Chililabombwe	17,155	16,407	109,160	96%
2.	Chilubi	17,000	14,682	69,596	86%
3.	Chingola	41,756	39,659	203,600	95%
4.	Chipata	50,000	45,817	124,199	92%
5.	Choma	30,000	25,527	103,545	85%
6.	Chongwe	40,000	36,473	80,708	91%
7.	Kabwe	44,000	37,749	175,586	86%
8.	Kafue	37,000	28,205	142,534	76%
9.	Kalulushi	17,440	13,423	65,147	77%
10.	Kaoma	31,800	28,320	77,127	89%
11.	Kapiri-Mposhi	21,000	20,433	88,883	97%
12.	Kasama	25,000	23,156	107,452	93%
13.	Kasempa	10,000	5,969	21,516	60%
14.	Katete	35,000	36,771	104,794	105%
15.	Kawambwa	16,000	14,913	76,473	93%
16.	Kazungula	21,000	15,597	74,612	74%
17.	Kitwe	70,000	56,585	251,785	81%
18.	Livingstone	24,600	20,664	51,456	84%
19.	Luanshya	25,500	23,907	136,593	94%
20.	Lufwanyama	13,800	11,276	53,589	82%
21.	Mansa	30,000	24,163	76,043	81%

22.	Masaiti	21,000	16,878	70,495	80%
23.	Mazabuka	62,000	56,541	160,188	91%
24.	Mbala	17,500	15,002	46,731	86%
25.	Mongu	26,500	27,226	112,155	103%
26.	Monze	15,000	10,882	50,268	73%
27.	Mpika	11,000	9,991	50,950	91%
28.	Mpongwe	37,300	27,890	98,957	75%
29.	Mufulira	34,789	31,684	164,716	91%
30.	Mumbwa	28,000	26,146	98,950	93%
31.	Nchelenge	27,600	30,938	166,345	112%
32.	Ndola	67,000	64,583	376,549	96%
33.	Petauke	50,000	30,551	93,133	61%
34.	Senanga	15,000	8,055	22,189	54%
35.	Solwezi	24,000	20,230	103,078	84%
TOTAL		1,054,740	916,293	3,809,102	86%

Table 2: Structures targeted and sprayed in 72 districts in 2011 IRS season

No.	District	2011			
		Target	Sprayed	protected	Coverage
1.	Chadiza	15150	14071	41630	93%
2.	Chama	23500	21484	53572	91%
3.	Chavuma	-	-	-	-
4.	Chibombo	22500	18142	21320	81%
5.	Chiengwe	14800	14794	63566	100%
6.	Chililabombwe	17155	16407	109160	96%
7.	Chilubi	17000	14682	69596	86%

No.	District	2011			
		Target	Sprayed	protected	Coverage
8.	Chingola	41756	39659	203600	95%
9.	Chinsali	20020	20395	48450	102%
10.	Chipata	50000	45817	124199	92%
11.	Choma	30000	25527	103545	85%
12.	Chongwe	40000	36473	80708	91%
13.	Gwembe	8000	6565	20237	82%
14.	Isoka	-	-	-	-
15.	Itezhi-Tezhi	10700	9231	24553	86%
16.	Kabompo	15200	11963	41573	79%
17.	Kabwe	44000	37749	175586	86%
18.	Kafue	37000	28205	142534	76%
19.	Kalabo	8700	8215	28242	94%
20.	Kalomo	13041	11455	42391	88%
21.	Kalulushi	17440	13423	65147	77%
22.	Kaoma	31800	28320	77127	89%
23.	Kapiri-Mposhi	21000	20433	88883	97%
24.	Kaputa	17000	7068	31154	42%
25.	Kasama	25000	23156	107452	93%
26.	Kasempa	10000	5969	21516	60%
27.	Katete	35000	36771	104794	105%
28.	Kawambwa	16000	14913	76473	93%
29.	Kazungula	21000	15597	74612	74%
30.	Kitwe	70000	56585	251785	81%
31.	Livingstone	24600	20664	51456	84%

No.	District	2011			
		Target	Sprayed	protected	Coverage
32.	Luangwa	6036	5478	10170	91%
33.	Luanshya	25500	23907	136593	94%
34.	Lufwanyama	13800	11276	53589	82%
35.	Lukulu	7230	6810	19480	94%
36.	Lundazi	30000	25789	99391	86%
37.	Lusaka	400000	339797	2433073	85%
38.	Luwingu	16200	7072	28291	44%
39.	Mambwe	16000	10548	30688	66%
40.	Mansa	30000	24163	76043	81%
41.	Masaiti	21000	16878	70495	80%
42.	Mazabuka	62000	56541	160188	91%
43.	Mbala	17500	15002	46731	86%
44.	Milenge	7,280	4378	18984	60%
45.	Mkushi	13001	7484	25291	58%
46.	Mongu	26500	27226	112155	103%
47.	Monze	15000	10882	50268	73%
48.	Mpika	11000	9991	50950	91%
49.	Mpongwe	37300	27890	98957	75%
50.	Mporokoso	11967	7932	39133	66%
51.	Mpulungu	10000	9923	61865	99%
52.	Mufulira	34789	31684	164716	91%
53.	Mufumbwe	15500	14725	25188	95%
54.	Mumbwa	28000	26146	98950	93%
55.	Mungwi	13000	12837	61865	99%

No.	District	2011			
		Target	Sprayed	protected	Coverage
56.	Mwense	10000	7488	33552	75%
57.	Mwinilunga	14000	10938	36116	78%
58.	Nakonde	16000	9524	31097	60%
59.	Namwala	19650	14807	40345	75%
60.	Nchelenge	27600	30938	166345	112%
61.	Ndola	67000	64583	376549	96%
62.	Nyimba	25571	18163	40676	71%
63.	Petauke	50000	30551	93133	61%
64.	Samfya	11200	11101	30953	99%
65.	Senanga	15000	8055	22189	54%
66.	Serenje	10549	10510	41699	100%
67.	Sesheke	-	-	-	-
68.	Shang'ombo	11174	8556	27650	77%
69.	Siavonga	15000	4889	14259	33%
70.	Sinazongwe	13440	13369	44152	99%
71.	Solwezi	24000	20230	103078	84%
72.	Zambezi	-	-	-	-
TOTAL		1,908,869	1,621,794	7,419,708	83%

Note: A dash (-) shows that data is not available

3.3.4 INDOOR RESIDUAL SPRAYING POST SPRAY MEETING

ZISSP supports the NMCC to hold a post spray meeting at the end of each spray season to review the performance of the IRS program and make recommendations for the next spray season. This past quarter, ZISSP funded a post spray meeting for 72 IRS managers, 72 District Medical Officers and nine Provincial Medical Officers. The private sector also attended the meeting, including Konkola Copper Mines, Mopani, Lumwana Copper Mines and Mazabuka Sugar Company. The meeting observed that delayed funding to districts, procurement and distribution of personal protective equipment (PPE) negatively affected the outcome of the campaign. The NMCC reported a national coverage of 83% which is below the WHO threshold. The meeting made the following recommendations:

- The MOH and IRS partners should fund the activities on time to avoid challenges of spraying during the rains.
- Procurement and distribution of PPE should be procured and distributed at least one month before the start of the spraying campaign.
- The MOH should ensure that new pumps are procured and distributed in sufficient time.
- Districts should prioritize IRS and ensure that this is carried out in areas with high malaria incidence and distribute ITNs in areas where IRS has not been done.

3.3.5 INTRODUCTION OF NEW INSECTICIDES IN SELECTED DISTRICTS IN 2012 IRS SEASON

Until 2011, DDT and pyrethroids were the main insecticides recommended for use in Zambia for IRS. The two formulations of insecticides contributed to a 53% drop in malaria parasite prevalence among children between 2002 and 2008. However, the emergence of resistance in the *Anopheles* species to these insecticides in most parts of Zambia threatened their continued efficacy. There are only four insecticide classes currently registered in Zambia and out of these four, only pyrethroids remain non-controversial with regard to human and environmental toxicity, and this is the only class currently licensed for use in ITNs in Zambia.

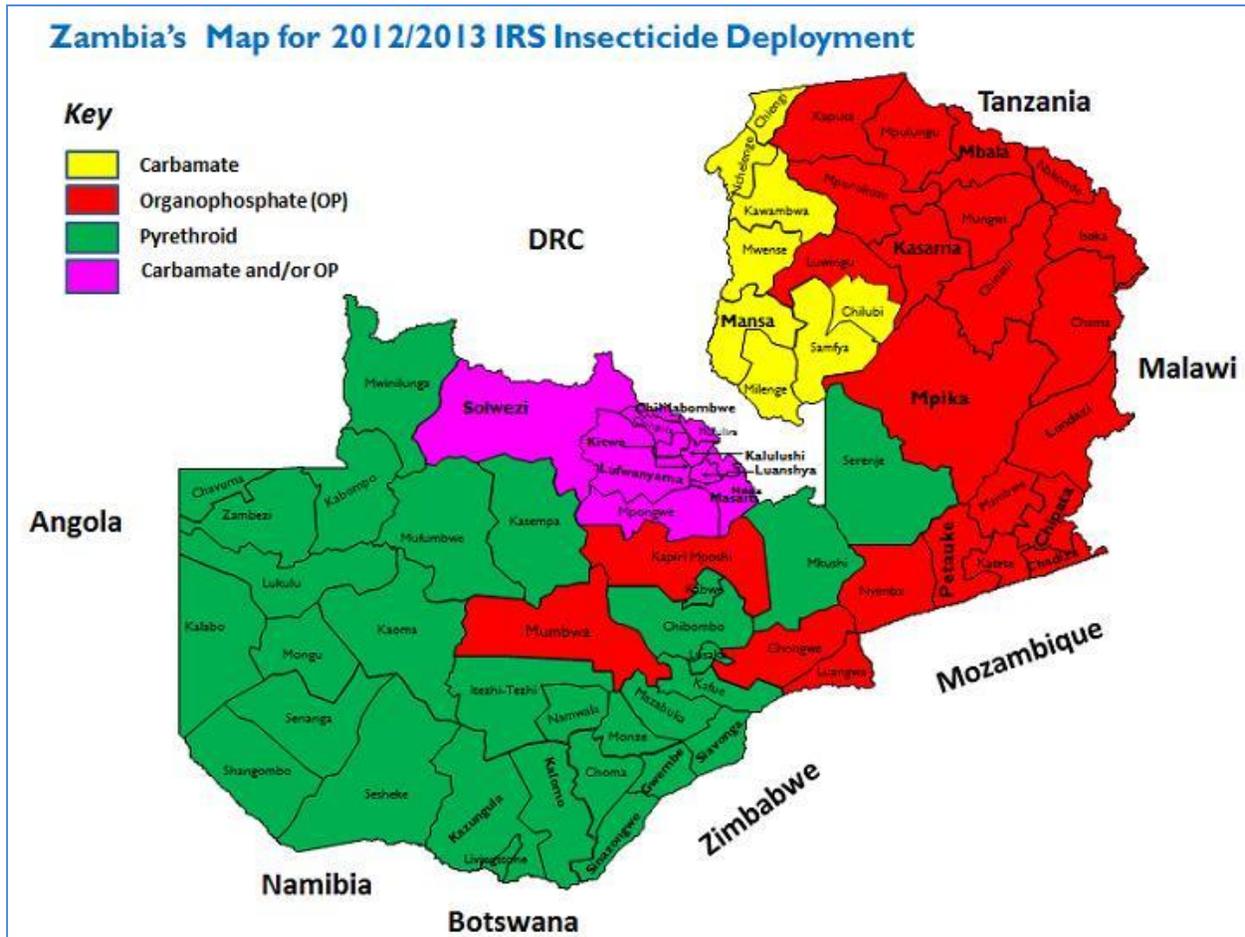
In 2012, ZISSP financed a TWG meeting to formalize the establishment of the Insecticide Resistance Management (IRM) TWG, whose main responsibility is to coordinate national insecticide resistance management. A team of entomologists drawn from the NMCC, ZISSP, Liverpool School of Tropical Medicine and other IRS partners involved in resistance monitoring in Zambia reviewed insecticide resistance data from 13 districts (Chadiza, Chililabombwe, Chipata, Kaoma, Kasama, Katete, Kitwe, Luanshya, Mufulira, Senanga, Solwezi, Mazabuka and Kasempa). The IRMTWG agreed that to effectively monitor and manage insecticide resistance, the NMCC should develop a spatiotemporal entomological profile that identifies areas with insecticide resistance and the underlying resistance mechanisms. To date, the mosquitoes from three sentinel sites (Katete, Kitwe and Kasempa) produced batches of eggs that NMCC staff sent to Liverpool. ZISSP plans to support the NMCC to collect mosquitoes from the remaining three sentinel sites to collect comprehensive data before the start of this year's IRS season. These data will establish a baseline for insecticide resistance trends and will support the 2012 plan for insecticide resistance.

The IRMTWG was also tasked to produce a map showing districts to be sprayed with selected insecticides based on the available data on insecticide resistance profiles of malaria vectors. The IRMTWG agreed upon the following four actions:

- Pyrethroids will be deployed in Southern, Western and North-Western Provinces (except Solwezi district where carbamates and/or organophosphates will be deployed). In Central Province all districts will receive pyrethroids except for Mumbwa and Kapiri Mposhi, where organophosphates (ACTELLIC 50EC) that do not require weekly bio-monitoring of cholinesterase in spray operators will be deployed.
- Carbamates and/or organophosphates will be deployed in Copperbelt Province where *kdr* mutations have been described in a *gambiae*. This is due to the high resistance detected in DDT and pyrethroids in major malaria vectors in the province.

- Carbamates will be deployed in Luapula Province due to greater compatibility with widely deployed long-lasting insecticide-treated nets (LLINs) that are treated with pyrethroids.
- Organophosphates (ACTELIC 50EC) will be deployed in Eastern, Northern and Muchinga Provinces.

The following map shows how the insecticides will be deployed in all the provinces of Zambia.



3.3.6 BUILD CAPACITY OF ENVIRONMENTAL HEALTH TECHNICIANS

Following the evidence of resistance to DDT and pyrethroids, all areas where IRS is being implemented require intense resistance monitoring. To achieve this, ZISSP trained 55 Environmental Health Technicians (EHT) selected from 35 districts in entomological monitoring field techniques (17 were female and 38 were male) and who will receive basic supplies to enable them to function effectively and report data to NMCC for decision making.

3.3.7 2012 MALARIA INDICATOR SURVEY

The Malaria Indicator Survey (MIS) is a representative national household survey assessing coverage of key malaria interventions and malaria-related effects among pregnant women and children under the age of five years. The Zambia 2012 national MIS 2012 represents a large-scale effort to benchmark progress of malaria control efforts and its disease burden. Zambia is the only country in the sub-region to have conducted three such surveys previously.

ZISSP provided financial and technical support to NMCC to train 100 health workers as research assistants for this MIS. The ZISSP team will continue to provide support to NMCC to monitor and supervise the research assistants until the MIS data collection has been finalized. The final MIS 2012 report is likely to be disseminated in August 2012.

3.3.8 TRAINING OF HEALTH WORKERS IN FOCUSED ANTENATAL CARE IN NORTH-WESTERN PROVINCE

According to the survey that was conducted by the MOH with support from ZISSP in 2011, only 41% of health workers in the selected districts were oriented to FANC within the last two years. This poses a challenge as many health workers may not be familiar with the latest guidelines. To build the capacity of the health workers ZISSP supported the MOH to train 40 health workers in FANC in North-Western Province in February 2012. The target groups were the CCT members and Maternal and Child Health Coordinators from all the districts in the province. The trained health workers will mentor other health workers in their health facilities in the latest FANC guidelines which should improve case management in malaria in pregnancy.

3.3.9 TRAINING OF HEALTH WORKERS IN MALARIA CASE MANAGEMENT IN SERENJE DISTRICT

In 2011, ZISSP supported NMCC to develop training materials to be used to disseminate the 2010 malaria case management guidelines. In the same period, ZISSP trained 205 health workers in the revised 2010 malaria guidelines in all the provinces. In 2012, the focus of case management trainings will be in the 27 ZISSP target districts. This past quarter, ZISSP trained 28 clinicians and nurses from health facilities in the revised malaria treatment guidelines. Emphasis was placed on the new guidelines of using Artemether-Lumefantrine as the first line drug for simple malaria and confirming malaria cases using rapid diagnostic tests (RDTs). During the three day orientation meeting, a full day was committed to practicums in the local health facilities where demonstrations on history taking, physical examination and performing an RDT were done. A session to brainstorm on the causes and solutions to the stock-outs of malaria commodities was conducted. The post-test evaluation indicated that there was improved knowledge in case management among the participants from an average of 60% to 80%.

3.3.10 TRAINING OF COMMUNITY HEALTH VOLUNTEERS IN COMMUNITY CASE MANAGEMENT

In Zambia, studies show that up to 80% of deaths in under-five year old children may occur at home with little or no contact with a health provider. The World Health Organization (WHO) recommends

integrated community case management (iCCM) as a strategy to provide good home care and promote survival, reduce morbidity, and foster healthy growth and development.

ZISSP provided financial and technical support to the Child Health Unit of the MOH to train 41 community health volunteers (CHVs) in iCCM in Luapula Province and 20 supervisors in Serenje District this past quarter. Through the Community Health Coordinators (CHCS), ZISSP will support the District Health Offices (DHO) to ensure that the CHVs are well supervised and provided with all the commodities needed to manage under-five children with malaria, pneumonia and diarrhea as per iCCM guidelines.

3.3.11 MALARIA ACTIVE INFECTION DETECTION IN LUSAKA DISTRICT

The MOH identified elimination of malaria in five districts by 2015 as one of the priorities in the 2011-2015 strategic plan. A necessary step towards malaria elimination is the enhancement of surveillance systems so that focal areas of malaria transmission may be identified accurately and responded to effectively. ZISSP together with the NMCC, PMI, Akros Research and Lusaka DHO, began surveillance enhancements involving malaria active infection detection (AID) in Lusaka District. Through AID, patients receiving positive confirmation of malaria at a local clinic are followed up through community response whereby community health workers (CHWs) visit the household of the patient and use RDTs to test all family members and neighbors for malaria parasites.

To progress towards ownership of the AID program by the Lusaka DHO, Akros and NMCC have worked with the DHO to ensure AID was included in the district's 2012 work plan and budget. A transition plan has been developed and the DHO has now assumed the oversight of AID in the initial five clinics. Akros staff continue to work with the DHO to ensure proper AID protocol is followed and necessary logistics are put in place. The transition of these clinics to the DHO has been a success so far adding to the sustainability of AID.

Given the success of AID, the MOH and DHO requested an additional five clinics to begin operating AID in their catchment areas. In March 2012, five new clinic staff were trained through a two day classroom and field-based training bringing the total AID clinics in Lusaka to 10 (five funded through the DHO, five funded through ZISSP).

3.3.12 PROFILING OF MALARIA IN LUSAKA HEALTH FACILITIES

In November 2010, all the MOH health facilities were visited and log-books reviewed to gather retrospective malaria data. Since then, ongoing review of facility logbooks has occurred on a monthly basis to gather data on the same malaria indicators to identify trends in clinical malaria cases, testing rates and dispensing of antimalarial. Meanwhile, case management trainings, microscopy trainings and ongoing and consistent communication and feedback between Akros, DHO, NMCC and the Lusaka health facilities has been put in place to increase the quality of diagnostics and case management in the district. The trends show that Lusaka clinics are testing more people for malaria than treating them based on clinical signs only. Further, fewer antimalarial drugs are being dispensed indicating that antimalarial drugs are being provided only to confirmed malaria cases. In fact, it has been shown that the knowledge that a confirmed malaria case leads to a community response (AID) has also led to an increase in use of correct case management guidelines.

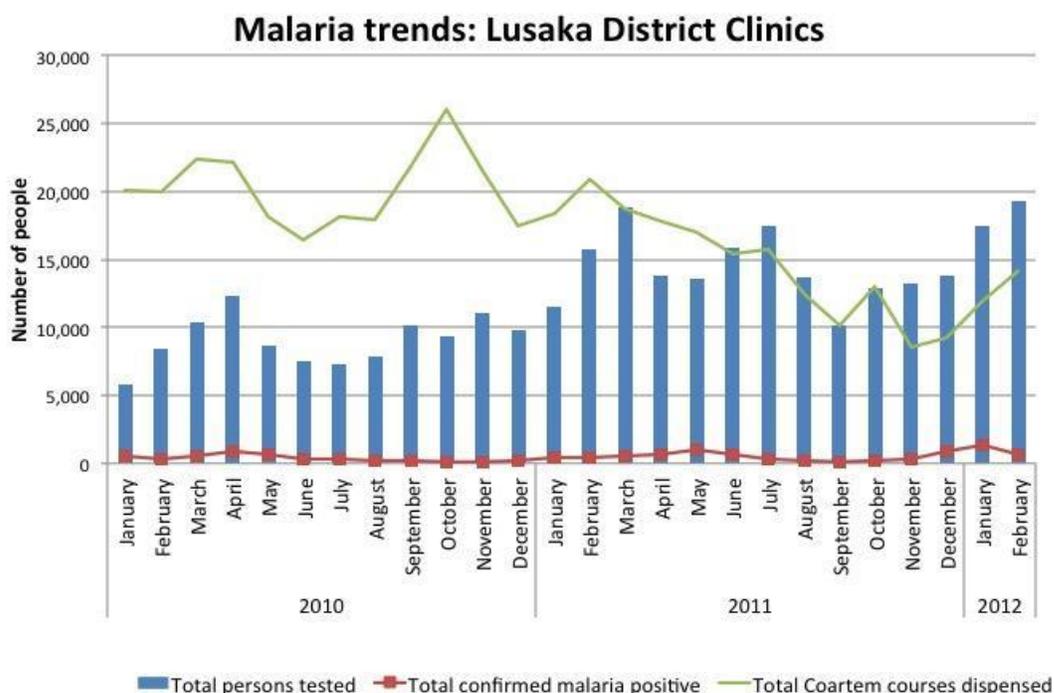


Figure 2 above shows that continual training and feedback to clinics on malaria case management, record keeping and diagnostics contributed to achieving successful results. Since 2010, there has been a noted increase in persons tested for malaria and a significant decrease in antimalarial (Coartem) courses dispensed.

3.3.13 AFRICA INDOOR RESIDUAL SPRAY PROGRAM

The United States Government, through USAID, announced the expansion of its IRS program in August 2011. Through the new project, Africa Indoor Residual Spray (AIRS) program, the PMI, led by USAID and implemented together with the Centers for Disease Control and Prevention (CDC), will provide technical and financial support to the MOHs and NMCC programs in African countries to build country-level capacity for malaria prevention activities. The \$189 million, three-year global contract awarded by USAID to Abt Associates will cover the implementation of IRS activities in Angola, Benin, Burkina Faso, Ethiopia, Ghana, Liberia, Madagascar, Mali, Mozambique, Nigeria, Rwanda, Senegal, Zambia, and Zimbabwe, with the possibility of expansion based on malaria control needs and availability of resources.

The AIRS activities include assessing the environment to ensure safe and effective use of insecticides, evaluating mosquito abundance and susceptibility to the insecticides, educating residents about IRS and how they should prepare their house for spraying. AIRS is also responsible for training of store keepers, drivers and other spray teams in safe management of insecticides, procuring of insecticide and equipment, and monitoring and evaluating spraying activities to ensure that they comply with WHO guidelines of safe chemical disposal. In Zambia AIRS is hosted and implemented through the ZISSP.

Currently PMI/USAID is supporting selected districts in Zambia and the AIRS focus will be on environmental compliance and procurement of IRS commodities.

In the first quarter, AIRS carried out post spray environmental compliance inspections in line with the regulations governing the IRS activities vis-à-vis Environmental Management Act Cap 204 of the Laws of Zambia and the USAID Environmental Procedures: Regulation 216. AIRS conducted field inspections in 68 districts which included inspecting and collecting data from IRS project facilities (soak pits, incinerators, wash areas and store rooms) and identifying areas requiring action using the post spraying Evaluation Checklist. It was observed that a number of districts are still using rented facilities for storage of insecticides and other IRS commodities and most store rooms do not meet the prescribed standards. ZEMA in collaboration with AIRS made recommendations to the Provincial Medical Office to provide support to the districts that did not meet the standards to make sure that they meet the standards before the next spray season.

4 TASK THREE: IMPROVE COMMUNITY INVOLVEMENT

4.1 SELECTION OF COMMUNITIES FOR FOCUSED ZISSP INTERVENTIONS

ZISSP is currently operating in all the provinces, targeting 27 districts. An exercise was undertaken at the beginning of the quarter to select focus communities based on set criteria. Four factors were considered in selecting focus health centers and their catchment communities.

1. Identifying and selecting facilities where ZISSP has retained health workers through the ZHWRS.
2. The health center having access to an EmONC facility which is considered critical for continuum of care and existence of a Safe Motherhood Action Group (SMAGs), since this group will have a critical function in this.
3. Considering communities with low institutional delivery and therefore having the greatest need to increase uptake of institutional deliveries.
4. Existing opportunities, i.e., health centers/communities where ZISSP has already invested in activities such as ZISSP having supported training of the Health Center Advisory Committee (HCAC)/NHC in health planning, iCCM, IYCF, C-IMCI.

The final selection of communities included 15 health centers per province. Health posts, hospitals and all mission and private facilities were not included in the selection.

4.2 TRAINING COMMUNITIES IN THE REVISED PLANNING HANDBOOK

In the first quarter of 2012, training of the HCAC and NHC members in community health planning was conducted in Mbala, Mansa, and Solwezi districts. A total of 60 members participated. The participants were drawn from 30 health centers across the three districts to build the capacity of community health groups in health planning. During 2011, ZISSP in partnership with the MOH revised the planning guidelines to include a section that provides health center staff and other partners' guidelines on how to engage communities in health planning. In the next quarter, the HCAC and NHCs will consolidate their community plans in readiness for the next MOH planning cycle.

4.2.2 TECHNICAL SUPPORT SUPERVISION FOR HEALTH CENTER ADVISORY COMMITTEES AND NEIGHBORHOOD HEALTH COMMITTEES

CHCs conducted quarterly support supervision visits to review the status of implementation of community plans and helped communities initiate the process of planning for the next phase in Mkushi, Kalabo, and Lufwanyama and Mansa districts. In each of these districts the CHCs visited the NHCs and

the HCACs in the targeted communities. Some of the highlights from these visits indicated that the selected communities in Mkushi and Kalabo districts were making progress. In Mkushi District the NHCs conducted community meetings and reached 134 members with key information on planning, initiated identification of community health problems and drafted action plans. Two action plans were completed and eight were in draft form in preparation for the MOH 2012/2013 planning cycle. In Kalabo, 213 of the 215 NHCs were active and conducted regular community meetings to plan for community sensitization activities to address malaria and typhoid, the latter due to an outbreak in Kalabo district. The NHC members shared roles and responsibilities to effect community sensitization activities.

4.2.3 DEVELOPMENT OF A CAPACITY BUILDING STRATEGY FOR COMMUNITY GROUPS

ZISSP in collaboration with the MOH staff from the central and selected provincial and district level convened a meeting to develop strategies to support capacity building of community groups based on the results of the community mapping exercise that was conducted by ZISSP in 2011.

Some of the key strategies identified include:

- Strengthening of community meetings and linkages between health centers and communities.
- Strengthening coordination amongst stakeholders with activities at the community level.
- Conducting training activities for HCAC/NHC in volunteerism and understanding their roles and responsibilities in health promotion and care.
- Introducing and strengthening the M&E system including supervision.
- Introducing quarterly review meetings for community groups during which updates on key health issues and procedures would be shared.
- Regular review of the implementation of plans and quality of implementation of activities.
- Integrating gender into all community activities.
- Engaging community leaders and other opinion leaders to participate in health related activities.

The capacity building strategy document will inform and guide the community team to critically review activities that aim at addressing gaps identified in the community mapping report. Finalization of the document will be accomplished in the next quarter.

4.2.4 REVIEW OF TRAINING MATERIALS FOR SAFE MOTHERHOOD ACTION GROUPS

ZISSP continued to hold discussions with the MOH on standardization of SMAG training materials. The content of these new guides produced with technical support from the ACNM needed to be aligned to acceptable standards and content required by the MOH. ACNM took the opportunity during subsequent training for SMAGs to solicit input in identifying sections of materials that needed to be

changed or improved upon. The revised training materials were provisionally accepted as appropriate as they were deemed to be more user friendly, using more visuals. The discussions to finalize the materials will continue in the next quarter.

4.2.5 CREATING A SYSTEM FOR TRAINING OF SAVE MOTHERHOOD ACTION GROUPS

ZISSP in collaboration with ACNM and in partnership with the MOH conducted a series of training activities using the revised SMAG training materials. The training used a cascade approach starting with the training of master trainers, trainers of trainers and finally the SMAG members as a means of creating a system for future training programs. The training activities targeted the following:

1. Master trainers: Sixteen were trained from Eastern, Luapula, and Southern Provinces.
2. SMAGs trainers: Twenty were trained from Kalomo, Lundazi, Mansa and Nyimba districts.
3. SMAG members: 228 were trained from Kalomo, Lundazi, Mansa and Nyimba districts and 95 SMAG members were trained from Luanshya, Luangwa and Shangombo.

Although these structured activities were aimed at supporting the Saving Mothers Giving Life Endeavor, this was also a major step to begin providing support of the SMAGs program to the MOH. CHCs from the above provinces were all oriented as observers to the training processes, and they helped facilitate SMAG members training activities by ensuring availability of logistics. In the next quarter, ZISSP, ACNM, and MOH will finalize discussions on materials to be used in the training of and agree on the supervision model for trained SMAG members. ZISSP and ACNM will further discuss and agree on the cascade model to reach SMAG saturation numbers in ZISSP target districts.

4.2.6 DEVELOPMENT OF A SUPERVISION SYSTEM FOR THE COMMUNITY HEALTH ASSISTANT PROGRAMME

ZISSP in collaboration with the MOH identified the need to engage a consultant (short term technical assistance) to facilitate the process of establishing a system for supervision of the Community Health Assistants (CHAs) trained under the CHA program. The scope of work for the consultant was developed. In the next quarter, the consultant will perform his/her assignment, including preparing and pre-testing of training materials.

4.2.7 DEVELOP DISTANCE RADIO LEARNING PROGRAM FOR SMAGs

ZISSP in collaboration with the MOH is developing a radio distance learning program on key safe motherhood messages that will complement the MOH SMAG training to provide timely health information that will promote positive behavior change to the target audience, who are women and men of reproductive age and other influential community members.

In the fourth quarter of 2011, the SMAG radio program entitled “Safe motherhood in our community,” scripts one to seven, were developed. Radio programs one and two have since been completed and pretested with the target audience. The pretest was done in Kafue and Chongwe with SMAG groups and revisions made based on the feedback.

4.2.8 INTERMITTENT PREVENTIVE TREATMENT FORMATIVE RESEARCH

Following the data collection that was completed in 2011, the research team continued with the research process. In this past quarter, transcribing of the data was completed. Data coding and analysis of the focus group discussions were completed and summaries of the themes with illustrative quotes within each were done and will be included in the results section of the report. The team is now coding and analyzing data for the in depth interviews.

4.2.9 BEHAVIOR CHANGE COMMUNICATION FRAMEWORK

After a peer review of the behavior change communication (BCC) framework (initiated through ZISSP support) by various stakeholders, ZISSP supported the MOH to hold a one day validation meeting. The meeting was a consultative process with stakeholders (IEC TWG and other BCC partners) to ensure that the framework document included all the relevant elements of the existing national health communication strategies and communication assessments. The stakeholders began to strategize on the most effective way to disseminate and roll out key highlights from the validation meeting. The groups further reviewed the framework for consistency of messages to ensure that they were based on national communication strategies.

The collaboration with Communication Support for Health (CSH) provided opportunities and identification of different roles that each partner would play at provincial, district and community levels during planning and implementation of BCC activities.

The purpose of the community BCC framework is to ensure coordination and synergy of BCC activities among stakeholders, provide guidelines for planning and implementation of BCC activities at district and community level, outline roles and responsibilities for BCC implementers and ensure harmonization and consistency of the BCC interventions across various BCC implementing stakeholders.

4.2.10 INVENTORY OF BEHAVIOR CHANGE COMMUNICATION MATERIALS

ZISSP engaged a firm to conduct an inventory of existing BCC materials at provincial, district and community levels in Zambia. During this past quarter, a research protocol was approved by local IRB, research assistants were trained and data collection has since commenced in Luangwa and Chongwe. Data collection and analysis will continue in Eastern and Western Provinces. Information gathered from this exercise will be complementing the community mapping exercise that ZISSP undertook earlier to gain deeper insight into the BCC status at the community level and provide guidance in developing a BCC strategy that will respond to community needs and also highlight appropriate strategies to be used at community level.

4.2.11 DEVELOPMENT OF THE DRAMA CAPACITY BUILDING STRATEGY

A workshop was conducted with ZISSP support to develop a drama capacity building strategy document this past quarter. While drama groups serve a key function at the community level, there are several challenges in their capacity, skills and ability to strategically deliver health and social messages as well as stimulate dialogue and discussion.

ZISSP's strategies for implementing community-level BCC activities include the use of local drama and community radio stations. The drama groups and community radio stations are also key resources mentioned in the Community BCC Framework. The drama capacity strategy will guide the capacity strengthening of the drama groups working with the MOH and other



A Kafue drama group performing at a workshop conducted to develop a drama capacity building strategy.

interested partners. This will also guide the development of a training of trainers curriculum and a video on training drama groups to be used as reference materials for standardized drama capacity building.

4.2.12 REVIEW THE DISTRICT HEALTH PROMOTION GUIDELINES

ZISSP in collaboration with the MOH and the IEC/BCC TWG conducted a workshop to revise the District Health Promotion Guidelines to improve health promotion program implementation at district and community levels. This revision resulted from the need to offer practical guidance for community program planning, implementation, and monitoring and evaluation.

The guidelines will be finalized in the second quarter. This will be followed by an orientation of the District Health Promotion focal persons and the district BCC committees to the revised guidelines.

4.2.13 GRANTS PROGRAM

During the past quarter, the main focus for the unit was on grant application and appraisal processes in order to select potential grantees. Other activities included the orientation of the National Grants Support Team (GST) to its role in the granting process and request for proposals. Key activities and achievements are outlined below.

4.2.13.1 BIDDERS' MEETINGS FOR POTENTIAL GRANTEES

District GSTs conducted bidders' meetings in the 11 districts participating in the 2012 Grants Program. The purpose of the meeting was to orient potential grantees to the program, including application and submission guidelines and procedures. A total of 178 participants from 290 non-governmental organizations (i.e., faith-based organizations and community-based organizations) participated in the meeting.

4.2.13.2 APPRAISAL OF GRANT APPLICATIONS

The appraisal of grant applications was conducted by provincial and district GSTs in all nine provinces and the 11 districts participating in the grants program. The main objective of the appraisal exercise was to select grantees in line with the established criteria. One hundred forty-four (144) applications were presented for appraisal. Twenty-eight applicants met the criteria for funding, and these were recommended to the MOH central level for endorsement and have since been forwarded to the national GST at ZISSP. The national GST is finalizing the selection process.

4.2.13.3 ORIENTATION OF THE NATIONAL GRANT SUPPORT TEAM

The community team in collaboration with the MOH Planning and Budgeting Unit held a meeting to orient the national GST to its roles in the granting process. Seven team members were taken through their various roles and functions regarding the review and finalization of selection recommendations from the provincial and district GSTs. Participants included planners from the MOH and ZISSP technical staff.

4.2.13.4 REQUEST FOR PROPOSALS FOR GRANT MANAGEMENT TRAINING CONSULTANCY

An advert to solicit applications from organizations to provide training and mentorship to grantees, to enable the grantees to implement their activities in line with USAID standard guidelines, was issued in the local print media. A total of 25 organizations expressed interest out of which 12 submitted proposals. These proposals will be evaluated based on set criteria, and the appropriate organization will be selected as the service provider.

5 CROSSCUTTING PROGRAM AND MANAGEMENT SUPPORT

5.1 MONITORING AND EVALUATION

5.1.1 PERFORMANCE MONITORING AND EVALUATION PLAN

The principal objective of the M&E team is to ensure that accurate, reliable, timely and verifiable data are captured in a consistent and efficient manner. The M&E team in collaboration with USAID revised the Performance Monitoring and Evaluation Plan (PMEP) which was first developed at program inception. The review of the PMEP resulted in redefined and realigned indicators while the Performance Indicator Reference (PIR) sheet provides a detailed definition for each indicator, data collection process, data sources and frequency of reporting data. The revised PMEP and the PIR sheet make maximum use of the existing data from the HMIS, ZDHS, and the MIS. Standard data collection forms specific to training and mentorship activities have been rolled-out. The rolling-out of the standard tools has made data collection analysis and tracking progress toward planned results easier.

5.1.2 PROGRAM MONITORING

Tracking of program activities and providing quality assurance are major activities that the M&E team implemented this past quarter. To strengthen the M&E processes, the M&E Unit enforced the implementation of standard data collection tools.

5.1.3 MONITORING AND EVALUATION DATABASE

The M&E team cleaned and continues to clean the database. In addition, the team developed a data submission certificate to help in further strengthening the tracking system of program training to ensure timely submission of the training and mentorship registers. This has and will continue to facilitate the data cleaning process and compilation of backup source documents.

The M&E team developed the M&E data processing and management guidelines which provide details of the data collection processes indicated both in PMEP and PIR sheet, a standard way of collecting program data, time of submission, data entry/cleaning, data audit, and back -up process.

5.1.4 DATA QUALITY ASSESSMENT AND AUDIT

ZISSP in conjunction with a team from USAID Zambia and the Pretoria Office implemented a Data Quality Audit (DQA) exercise. The exercise focused on verifying malaria, health and nutrition data for the period October 2010 to September 2011 in Chongwe district. ZISSP is still waiting for a written report on the findings from the USAID M&E team. Despite the report not being ready, ZISSP has started implementing some of the findings which include clearly labeling the files, setting up a filing system for the participation forms, developing an M&E policy, and compiling data source documents.

5.1.5 TECHNICAL SUPPORT

The M&E unit provided technical support to the MOH during the Joint Annual Review during this past quarter. The M&E team participated in putting together the terms of reference, the tools, data and report writing. The team has continued to provide technical support to the M&E TWGs.

Additionally, the M&E team worked with the Human Resources Specialist to develop a scope of work for assessing the ZHWRS, as well as a SMAG data collection tool. The team also pre-tested the community radio program for the SMAGs and baseline assessment tools for the radio program.

5.1.6 BASELINE SURVEY

ZISSP has made headway in implementing the baseline survey. Meetings have been held with the consultant who is currently reviewing secondary data. The M&E team in consultation with USAID, program staff and senior management, has completed reviewing the PMP which will be submitted to the consultant to facilitate the development of data collection tools for the baseline survey. The indicator reference sheets for all the indicators have been finalized.

5.1.7 REPORTING AND ABSTRACT REVIEW

The M&E unit compiled and submitted the annual (January – December 2011) progress report which outlined the targets, achievements and the constraints faced in meeting ZISSP's set targets. In addition, the unit worked with the program staff to develop and submit seven abstracts to demonstrate some of the successful activities which the program has done since its inception: the American Public Health Association (APHA) and the XIX International AIDS Conference. The abstracts submitted to the International AIDS Conference include Supporting Clinical Care Teams to Improve Quality of ART Services in the Southern Province of Zambia and A Model for Integrated Service Delivery and Improved HIV Case Management, both of which have been accepted for a poster presentation. Abstracts submitted to APHA include Measuring the Competencies and Skills of Midwives in an Accelerated Training Program in Zambia, Challenges of Implementing Intermittent Preventive Treatment in Zambia for Malaria Prevention in Pregnancy, The Zambia Management and Leadership Academy - an Innovative Approach to Building Management and Leadership Capacity within the Zambian Health Sector and Ensuring Equitable and Efficient Allocation of Resources in a Resource Constraint Environment- the Case of Zambia.

5.1.8 RESEARCH ACTIVITIES

The M&E team and the program staff have been working with the consultant in report writing for the IPT formative research, and Direct Entry Midwives (DEM) assessment. The aim of the IPT formative research is to establish factors that inhibit malaria prevention efforts during pregnancy in Zambia, as well as provide insight into broader issues around ANC barriers and facilitators to accessing antenatal services early in pregnancy. The findings of the research will be used to inform the development of messages and other communication products that are relevant to addressing the findings. The DEM assessment is aimed at evaluating the DEM training program and performance-based analysis on

capabilities of the certified midwives. The findings from this survey will be used to validate recommendations for enhancing the quality of training and practice for the program.

5.2 KNOWLEDGE MANAGEMENT

5.2.1 TECHNICAL BRIEFS AND SUCCESS STORIES

ZISSP continued to develop success stories in different technical areas (malaria, family planning, maternal, newborn, child health and nutrition) to demonstrate impact of program implementation. Staff continued to be guided by the unit on how to write a good success story through sharing of information on the subject, including a guide to writing a success story and some presentations from USAID which provided an overview of what a success story should include and the different necessary accompaniments such as photographs and subject consent release forms. The success stories for this past quarter are included in section seven of this report.

5.2.2 INFORMATION SHARING AND TOOLS

The Knowledge Management Unit continued sharing various reports and other useful information, for example, an article on “Country ownership and strengthening health information systems”. The various reports shared include the World Malaria Report 2011 and the Annual ZISSP Report for 2011. Using the Dropbox and NXPowerlite approach has continued to improve accessing of information by ZISSP both at the central office and by provincial staff.

5.2.3 COMMUNICATION STRATEGY

Strategic communication is increasingly being recognized as an essential element of any successful health program. Communication is also essential in overcoming barriers to access to health services or generating demand for such services. The ZISSP Knowledge Management Unit shared an internal discussion guide with the technical teams to solicit input on what to consider in developing the strategy such as “what is ZISSP trying to achieve with internal communication” and “what should be done to improve internal communication”. In the coming quarter the feedback from the teams will be compiled and consolidated and the same process will be carried out with ZISSP’s external audience.

5.3 CAPACITY BUILDING

5.3.1 DEVELOPMENT OF MENTORSHIP TRAINING CURRICULA AND MATERIALS

The unit worked closely with the CCT to ensure that the mentorship training materials, i.e., guidelines, facilitator and participant manuals and tools, to be used in facilities during mentorship were finalized by a local consultant. The training materials have since been approved for use in all health sector mentorship training. The materials are ready for printing.

The unit also completed the quality improvement guidelines and the facilitator and participant quality improvement manuals, working closely with the CCT. These were subsequently presented to a consultant from the Regional Center for Quality of Health Care based in Kampala, Uganda for an expert's review, which has been done. All three documents are provisionally ready for use in the training of health workers.

5.3.2 COMMUNITY HEALTH ASSISTANT PROGRAM

The unit provided direct technical support on a monthly basis to the CHA training school. ZISSP through the Capacity Building Specialist submitted the school rules for adoption and use in governing the students. As a result, no student has since withdrawn from the program compared to the first six months when the number dropped from an initial enrollment of 330 to the current 307.

The Capacity Building Specialist:

- Created a students' profiling system through helping to set up student personal files comprising all vital information, such as continuous assessment records, sick notes, and any other information of relevance.
- Facilitated the creation of vital personal files for all tutors to be kept by the Principal Tutor.
- Facilitated the inspection of the CHA school by the University of Zambia (UNZA) for purposes of program affiliation. The school has since been inspected and awaiting the final report from UNZA.
- Developed a curriculum outline for CHA supervisors and which has been approved by the CHA strategic team comprising the MOH, CHAI and ZISSP. The outline has since been submitted to the local consultant for final detailing.

5.3.3 CAPACITY BUILDING STRATEGY FOR COMMUNITY HEALTH COORDINATORS

The ZISSP capacity building specialist facilitated an internal capacity building workshop for the CHCs where a strategy for community capacity development was developed based on results from the community mapping study done in 2011.

5.3.4 EMERGENCY OBSTETRICS AND NEWBORN CARE

The Capacity Building Specialist provided technical advice and support in mentorship skills during the training of national trainers for EmONC focusing on the main principles of the new generic mentorship program. During the training, the EmONC trainers observed that there was need to review and strengthen the EmONC tool in the current mentorship manual.

5.3.5 GENDER INTEGRATION

The unit, working together with a consultant from the Center for Development and Population Activities (CEDPA) drafted a gender strategy resulting from a consultative and participatory process involving ZISSP team members. The strategy is ready for submission to the Senior Management Team

for further consideration and approval for implementation. The purpose of the strategy is to guide the integration of gender in all ZISSP programming.

5.4 FINANCE AND ADMINISTRATION

To effectively contribute towards achieving ZISSP's program goal, the Finance and Administration Department enhanced comprehensive support to the FY2012 work plan budget processes. The first quarter operation strategy for the Finance and Administration Department was to ensure that all processes, financial or otherwise, were well integrated and cost effective. To achieve this, the department ensured that the Time Card System was established and functional within this past quarter. This was coupled with the roll-out of the Online Time Reporting system for more efficient and timely submission of time sheets. All these systems did not only improve cost effectiveness but also improved the general business operations for the Finance and Administration Department as well as other departments.

As vendors are a vital partner and viewed with high esteem in the effective implementation of the ZISSP activities, the Finance and Administration Department initiated deployment of a more transparent way of doing business with competent and unquestionable vendors. The department undertook a vendor due diligence process to ensure that all diligent vendors were registered and a draft report presented to management on the whole process. The department also started to develop Service Level Agreements for frequently purchased items to ensure value for money through quantity discounts. The department also established a procurement tracking system which feeds into an online tracking system called International Site Management System (ISMS). All these culminated in a reduction of time spent on looking for competent vendors, requesting repeated quotations and the establishment of an integrative data system.

To ensure effective and efficient internal controls, the department intensified the follow up of outstanding project advances with staff to ensure minimal accrued expenditures and an increased burn rate for the end of quarter. The department also reviewed and recommended revised controls in the petty cash system to the home office to ensure proper accountability in the use of petty cash.

The basic operations strategy for the Finance and Administration Department to achieve all the above financial operational activities was a well-established minimum Key Performance Standard aimed at ensuring effective and efficient support to the program as a whole.

5.5 OVERALL BUDGET AND EXPENDITURES ANALYSIS

As at 31 March 2012, ZISSP spent a cumulative total of \$24,310,842 against the current year-to-date obligation of \$42,201,555.00. This resulted in an overall cumulative percentage expenditure of 27.60% against the total program estimated budgeted amount of \$88,092,613.

5.6 HUMAN RESOURCES

ZISSP has a total of 93 staff including four senior management staff, 49 technical staff, 15 finance and administrative staff, and 25 drivers.

The project recruited one M&E officer, four district coordinators, one staff for the Saving Mothers Giving Life Endeavor and one nutritionist. ZISSP is in the process of recruiting two clinical care specialists for Luapula and Eastern Provinces and an assistant accountant.

5.7 MAJOR CHALLENGES AND RESPONSE

CHALLENGE	STEPS TAKEN TO ADRESS CHALLENGE
Failure to second Clinical Care Specialists to two provinces due to non-availability of eligible candidates causing a delay in activity implementation.	Efforts are still underway to ensure that these positions are filled.

6 FOCUS AREAS FOR QUARTER TWO, 2012

Below are the key activities planned for the next quarter by each of the major ZISSP technical programs areas:

MATERNAL, CHILD HEALTH AND NUTRITION, FAMILY PLANNING, AND HUMAN RESOURCES

HRH

- Provide technical and financial support for implementing the Workload Indicators for Staffing Needs.
- Hold one HRH quarterly performance review meeting.
- Undertake one capacity building program based on the capacity needs assessment of 2011.
- Provide technical support for the 2013 MOH planning cycle.
- Initiate the process of developing the HRH communication strategy.
- Provide support to finalize the process of providing the MOH with direct access to PMEC data.
- Continue providing support for the ZHWRS.
- Complete the retention scheme audits.

EmONC

- Provide support for four EmONC trainings with preceding site assessments.
- Provide support for four post-training supportive supervisory visits.
- Provide support to develop the protocol for the EmONC impact survey.
- Undertake four EmONC manager's orientation.
- Facilitate the provision of supportive supervision to the three DEM schools skills laboratories.
- Provide support for the 2013 MOH planning cycle.

Child Health and Nutrition

- Conduct four IMCI trainings.
- Conduct one computerized IMCI training (ICATT) for nurse tutors.
- Undertake baseline assessments for implementing comprehensive child health corners in three districts.
- Undertake three IYCF trainings for health care workers and four community IYCF/CBGMP trainings for community health promoters.
- Conduct three trainings for health care workers in nutrition and HIV.
- Undertake Baby Friendly Health Facility Assessments in five districts.
- Provide support for the 2013 MOH planning cycle.
- Undertake trainings for mentors from five districts.
- Undertake a training of trainers for community IYCF.

Family Planning and Adolescent Health

- Conduct training of 40 health care workers in LTFP.
- Undertake a training of trainers for 18 trainers in LTFP.
- Undertake training of trainers for community-based family planning provision.
- Facilitate training of 60 family planning community-based distributors.
- Facilitate training of 60 health care workers and 60 peer educators in adolescent health.
- Conduct a needs assessment in gender and youth friendly services.
- Facilitate the development of the adolescent reproductive health communication strategy.
- Provide support for the 2013 MOH planning cycle.

Malaria

- Conduct training in IRS, iCCM, insecticide poisoning, malaria case management, FANC and IRS logistics.
- Review and develop strategic documents and tools (IRS, FANC, IPTp BCC materials, IRS logistics training materials, and M&E Newsletter)
- Carry out incineration of insecticide waste
- Procure insecticides and equipment through AIRS
- Carry out entomological investigations
- Carry out Active Case Surveillance
- Support BCC for malaria

Quality Improvement and Clinical Care

- Participate and support monthly national QI TWG meetings at MOH.
- Train six QI training of trainers from each of the 10 provinces in two sessions.
- Initiate the training of 405 DHO/hospital staff (15 in each of the 27 target districts) in QI to institutionalize QI at all levels of health service delivery.
- Revamp QI and technical committees at all levels.
- Facilitate one-day provincial quarterly inter-district performance reviews.
- DHOs to facilitate formation or revitalization of the health facility QI committees.
- Clinical Care Specialists to facilitate district QI teams in providing technical assistance for a one day self-assessment exercise at five health facilities in each of the 27 target districts.
- Support and facilitate MOH dissemination/launch of the clinical mentorship and quality improvement guidelines and the revised training packages.
- Provincial and district CCTs facilitate planning meetings for clinical mentorship, multi-disciplinary health worker staff professional development for QI through clinical mentorship, and clinical meetings.
- Provide technical assistance to developing planning updates in the clinical areas for the 2012-2013 MOH planning cycle and facilitate planning launches in the provinces and the districts.

Community Health Coordinators

- Build capacity of MOH staff at district and facility levels to engage communities in health activities.
- Provide financial and technical support to MOH staff in engaging communities in planning activities.

- Develop and print materials to guide activity implementation at district and community levels, e.g., for SMAGs training and supervision and materials and guidelines for community participation in health activities including the BCC framework.
- Strengthen implementation of the CHA program through capacity building of tutors and strengthening the M&E and supervisory system for this program.
- Implement the grants program in 11 districts.
- Conduct inventory of BCC materials.
- Implement the RDL and conduct RDL assessments.
- Develop a strategic plan for drama capacity building.
- Finalize IPTp formative research.
- Finalize grant selection process, seek approval from USAID and fund grantees.
- Select consultant and train grantees in grant management.
- Facilitate implementation of activities by grantees.

Management Specialists

- Provide technical assistance and participate in the MOH launch of the annual planning cycle at central, provincial, district and hospital levels.
- Provide technical to the MOH to train trainers in the customized MBB toolkit and support initial roll out to two selected provinces and districts.
- Conduct resource mapping in 27 target districts and produce report on the same.
- Provide technical assistance to MOH central level to hold a consensus meeting for stakeholders to finalize revision of the performance assessment tools and accompanying standards.
- Provide technical assistance to seven remaining provinces to develop provincial statistics bulletins.
- Participate in technical support supervision to institutions following performance assessment activities conducted in the first quarter of 2012 to provide mentorship in management functions.
- Develop tools and checklists for monitoring performance of programs in relation to management functions (action plans, data usage, financial procedures, etc.).
- Conduct second round of MLA trainings and provide mentorship to MLA participants as reflected in roll out plan.

Monitoring and Evaluation

- Compile a semi-annual performance, Portfolio, PEPFAR and quarterly reports.
- Finalize the baseline survey.
- Provide technical support to program staff in developing technical briefs and success stories.
- Update, clean the database and data verification.
- Finalize the formative research and the DEM assessment reports.
- Conduct field data quality assessment and audits.
- Provide technical support in the preparation of the 2012 ZDHS.
- Conduct monthly CHA supervision training of CHA supervisors in provinces.
- Review of the current EmONC mentorship tool.

7 SUCCESS STORIES/ TECHNICAL BRIEFS

7.1 Improvements in Malaria Surveillance in Lusaka District, Zambia: a Key Step Towards Malaria Elimination

The story of malaria in Lusaka district, home of Zambia's capital city, is evolving. Although malaria surveys indicate that the malaria burden is near zero especially compared to other parts of the country, public clinics throughout the district continuously reported well over 100,000 to 200,000 or more malaria cases annually and consequently dispensed high amounts of antimalarials. The Zambia Integrated Systems Strengthening Program (ZISSP), through its work with the Lusaka District Health Office (DHO), Akros Research, Malaria Control and Evaluation Partnership in Africa (MACEPA), Improving Malaria Diagnostics (IMaD), and the National Malaria Control Center's (NMCC) laboratory quality assurance team, implemented malaria active case surveillance (ACS). This program provides a feedback loop to clinic staff allowing them to review malaria trends at their clinic and improve the quality of their diagnostics and adherence to malaria case definitions. Through these measures, Lusaka district experienced a marked reduction in malaria cases reported and antimalarial prescriptions dispensed during 2010 and 2011.

Through this program, clinicians in Lusaka district are reversing previous assumptions that the malaria burden within the district is high, accepting instead that there is actually very little true malaria within the district. The malaria ACS program, which reviews clinic logbooks and provides feedback to public clinics each month, is encouraging clinicians to reconsider case management practices, specifically, whether patients with fever ought to be classified as having malaria without laboratory confirmation. Clinicians are gaining increased trust in laboratory diagnostics and are reducing the number of clinical malaria diagnoses, which has drastically reduced the number of antimalarial drug prescriptions.

Many DHO personnel no longer question whether there is malaria in Lusaka – as there are very few confirmed cases – but are now considering how to support clinicians in best-practice case management guidelines as published by the Ministry of Health (MOH). Wholesale adoption of these guidelines among Lusaka clinicians has been a challenge for several reasons, including perceived unreliability of malaria rapid diagnostic tests (RDTs) and the knowledge, particularly from recent graduates, that malaria is high throughout sub-Saharan Africa. Changing this mind-set is the purpose of many of the visits made to public clinics through the ACS program during the monthly collection of data.

The positive effects of the program are visible. Data from 2010 to 2012 show a gradual and sustained reduction in the amount of antimalarials dispensed by facilities throughout the district, with the total antimalarial consumption drawing closer to the total confirmed malaria cases. These data demonstrate that clinicians are increasing their trust in malaria tests conducted within the laboratory instead of prescribing antimalarials based only on clinical factors. This alone represents great strides towards the MOH's goal of quality case management.

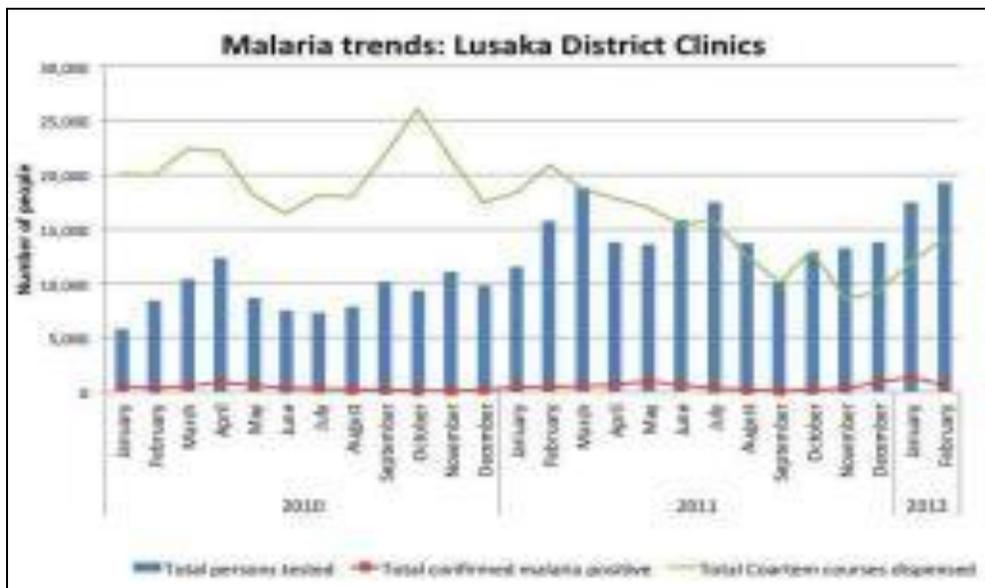
To continue this positive trend, the Lusaka DHO and its partners planned several meetings with local clinic in-charges and clinicians to continue encouraging adherence to malaria case definitions. These trainings will focus on ensuring that clinicians continue to adhere to MOH case management guidelines and encourage the prescription of antimalarial drugs only to those with diagnostically confirmed malaria.

Lusaka district has indeed come a long way from the days when every fever case that walked through the clinic door was immediately considered “malaria.” Very few confirmed malaria cases are now reported and evidence indicates that most true malaria is imported from high burden areas of Zambia and its environs. Owing to these positive developments, novel strategies of malaria surveillance and control strategies are being conducted in the district. These include follow-up of malaria cases in the community to identify if hotspot areas of malaria transmission exist and providing treatment and bed nets as necessary. The effort and time required for each case follow-up stress the need for accurate reporting of true malaria cases. Expansion of the ACS system is a key component as Zambia progresses towards its ambitious goal of malaria elimination in five geographical areas by 2015.

Figure 1. During a monthly visit to Chainda clinic, an ACS program staff reviews clinic registers with clinic staff and provides feedback on the previous month's data.



Figure 2. Continual training and feedback to clinics on malaria case management, record keeping and diagnostics since 2010, resulted in noted increase in persons tested for malaria and a significant decrease in antimalarial (Co-artem) courses dispensed.



7.2 Skills Lab Models Boost Midwifery Schools Performance

Three Direct Entry Midwifery (DEM) schools had for many years been faced with the problem of inadequate models in the skills laboratories. The available models were insufficient for all the students to use during the training, and this greatly affected their performance.

The three DEM schools were initiated by the Ministry of Health (MOH) in 2008 to train enrollees straight from high school to become certified midwives and as a scale up strategy to help resolve the human resource crisis in nursing and midwifery practice. The Roan, Nchanga and Chipata Midwifery Schools have graduated 159 certified midwives.

“It is very difficult to simulate postpartum hemorrhage (PPH) in the skills laboratory without proper models,” lamented Lillian Zulu, a second year midwifery student at Roan the Midwifery School.

The lack of models in the skills laboratories prompted the USAID-funded Zambia Integrated System Strengthening Program (ZISSP) and the American College of Nurse Midwives (ACNM) to provide much needed support to the three schools by donating various models and simulators. Thirteen of the tutors and clinical instructors were also trained in skills laboratory management.

Emelda Chalabesa, a second year student at Roan Midwifery School, could not hide her excitement, “This is the best gift that this school has received. The models that we had before were not enough and it was very difficult to learn in the skills lab. Most of the equipment is found in the clinical area but now we’ll have our own equipment to use here in the lab for practicing before we go to the clinical areas.”

As a result of the training and the models provided to the three institutions, instructors and tutors are now better equipped to teach their students. Similarly, students are more engaged in their learning environment.

With models like the MamaNatalie and NeoNatalie, the students now find it easy to learn how to manage PPH as they are actually experiencing something more close to a real situation.

“With the new models and equipment, we’ll now enjoy learning in the skills lab,” said Mable Shibemba, a student at Nchanga Midwifery School.



Georgina Chipowe, (on the bed) a tutor at Nchanga Midwifery School, coaches a midwifery student (standing) on how to perform obstetric palpation using the newly donated MamaNatalie model.



Tutors prepare for a demonstration using the newly donated MamaNatalie model while students use the demonstration checklist to follow the procedure at the Nchanga Midwifery Skills Laboratory

7.3 New Guidelines Improve Malaria Case Management

“What can they possibly teach me about malaria that I do not already know?”

This is the question most clinicians asked themselves several times when they received yet another invitation for a three day training on the new malaria guidelines.



Kitwe District Medical Office Pharmacist Nalishabo Siyandi explains how RDTs work.

For many years, medical training taught health providers to assume that every fever should be treated as malaria. This came to the fore in reports on malaria cases in 2011. Clinicians based their diagnosis and treatment of 52% of their patients on clinical symptoms rather than laboratory tests.

What the clinicians did not know was that in 2010, the Ministry of Health (MOH) developed new clinical treatment guidelines for malaria, including a new protocol for malaria diagnoses based on rapid diagnostic tests (RDTs) rather than patient symptoms.

To address this and other gaps in compliance with the new guidelines, Dr. Shichitamba-Wamulume, Case Management Specialist from the National Malaria Control Center (NMCC), and Dr. Peter Mumba from the USAID-funded Zambia Integrated System Strengthening Program (ZISSP) trained health care workers. The concept for this training was based on the lessons learned from the effective strategy to initiate clinicians to updated guidelines in 2008 for Zambia’s HIV program.

After 90 frontline health workers were trained in Kitwe on the malaria guidelines, significant changes in the way clinicians in their health centers were treating malaria were observed. One of the most important was the consistent use of RDTs.

By quickly orienting providers to the important changes instead of simply disseminating new documents, HIV clinicians began to comply with the new treatment guidelines more quickly after the focused training than after just receiving new documents.

Following the training, Kitwe had a noticeable drop in the number of cases of malaria that the facilities reported as diagnosed through clinical symptoms. There was also a rise in the orders for RDTs. In the first quarter of 2011, one health facility in the district (Ndeke clinic) recorded 1,142 cases of clinical malaria and 826 cases of confirmed malaria. After the training in 2012, the clinic recorded only 99 clinical cases and 967 confirmed cases.

“The best news is that our consumption of antimalarial drugs is also declining. At Ndeke clinic, 12,720 doses of Artemisinin combination therapy (ACTs) were consumed in the first quarter of 2011 but only 3,970 doses were consumed during the same period in 2012. As a result, we are saving money from our discretionary drug budget which we used to purchase more anti-malarial drugs when the allocation

from the Central Medical Stores ran out. Now we can buy other urgently needed drugs instead,” explained Dr. Chelbin Mwila-Mukuka, Kitwe District Principal Clinical Manager.

“During the training, I was very surprised to find that there were plenty of improvements in the treatment guidelines which I needed to know,” said Dr. Kennedy Gondwe, the Medical Officer from Kitwe Central Hospital.

As health providers begin to use RDTs to confirm every case of malaria before treating it, the health system will save money. A course of ACTs to treat malaria costs about \$14.00, which is quite substantial in comparison to the prior chloriquine treatment which averaged less than \$2.00 per episode of illness. These savings will add up in a country that reported 4.7 million cases of malaria in 2011.

Some patients in the health centers observed the difference as Edith Nambela, a 37 year-old patient from Ndeke stated, “Now the clinical officer gives us a quick test to know for sure if we have malaria. In the past, they would sometimes say that they wanted to treat for malaria just to be safe. Now we are sure.”

The experience with new malaria guidelines illustrates that it is not always sufficient to update clinical guidelines to introduce best practices. The training and support from ZISSP and MOH helped clinicians quickly understand and implement key guideline changes. ZISSP will continue training on malaria case management in other target districts and monitor clinical indicators to see evidence of changes in practice. In addition, the project intends to work with the MOH Directorate for Clinical Care and Diagnostics to find more effective ways to train providers in all new clinical guidelines.



Anderson Mumba, a Clinical Officer at Ndeke Clinic, conducts an RDT on his patient, Edith Nambela, to determine if she has malaria.

7.4 Innovations during Emergency Obstetric and Neonatal Care Training: Cervical Tear Inspection and Repair Using a New Sock Simulator

The Emergency Obstetric and Newborn Care (EmONC) program in Zambia aims to address the high mortality rate of 591 per 100,000 live births (Zambia Demographic Health Survey, 2007). The goal of the program is to build capacity among the health care providers (doctors, midwives, nurses, clinical officers and medical licentiates) to effectively manage obstetric emergencies thereby contributing to the reduction of maternal and newborn morbidity and mortality. The full rollout of EmONC training started in 2007 and to date, close to 600 health care providers have been trained.



Foam cervical tear repair simulator model commonly used in EmONC training.

The largest contributor to maternal deaths in Zambia is postpartum hemorrhage (PPH). Since cervical tears are a major contributor to PPH, the EmONC training curriculum includes cervical inspection and repair. Trainees have traditionally acquired these skills using a foam simulator model. The drawback of this model is that it does not effectively simulate the difficulties of cervical inspection and repair in an actual pelvis.

To give students a more realistic depiction of these procedures, a Zambia System Strengthening Program (ZISSP) consultant from the American College of Nurse Midwives, Ms. Diana Beck, introduced a sock simulator fitted in a pelvic model in October 2011. The sock appears more like a uterus and the outer edge of the sock better resembles a cervical tear than the foam model. Subsequently, this innovation has been fully adopted as part of the simulation models for EmONC training in Zambia.



Sock cervical tear simulator developed by ZISSP and ACNM to provide a more realistic training experience.



J Banda (seated, left), a national EmONC trainer, oversees the demonstration of a cervical inspection for trainees using the new sock model.

Mr. James Banda, a national EmONC trainer, explains: “The introduction of the sock model has made demonstrations easier as trainees are able to grasp and acquire the skill faster.” With this innovative sock simulator, EmONC trainees find it easier to put knowledge and skills learned during training into practice.

7.5 Building Community Capacity for Safe Motherhood through Safe Motherhood Action Group Training in Lundazi

Zambia has a maternal mortality rate of 591 deaths per every 100,000 births (Zambia Demographical Health Survey, 2007), one of the highest in the world. Through the “*Saving Mothers, Giving Life*” (SMGL) endeavor, the Ministry of Health (MOH) is actively working with its cooperating partners to reduce maternal mortality by 50% in four target districts: Kalomo, Nyimba, Lundazi and Mansa. The MOH and its partners recognize that effective strategies for reducing maternal mortality involve mobilizing and sensitizing communities on safe motherhood practices. Safe Motherhood Action Groups (SMAGs) provide one mechanism through which this can be achieved.

The Zambia Integrated Systems Strengthening Program (ZISSP) provided the MOH with technical and financial support between February and March 2012 to conduct cascade training for provincial, district and facility level health care workers from the four SMGL districts. First, 16 provincial and district level health care workers were trained as SMAG master trainers, and 20 facility level health care workers were trained as SMAG trainers. These individuals in turn trained 320 community members in the four districts to become SMAG members. Eighty of these community members were from Lundazi district, from communities around Nkhanga, Mtwalo, Chikomani, and Chitungulu health centers.



The community members were active participants in the training sessions which used picture cards and demonstrations to teach them how to conduct community meetings and teach fellow community members about safe motherhood practices. The participants took pre- and post-tests to demonstrate knowledge gained from the training. Pre-test results ranged from 20-50% and post-test results ranged from 75-100%, indicating a clear improvement in knowledge gained. Josephine Phiri, a community member from the Mtwalo community who was trained as a SMAG member said, “We are grateful for the training and feel empowered to go and teach people in our communities using the pictures we have been given and the knowledge we’ve gained.” SMAG training is a useful way to build the capacity of community members to effectively build safe motherhood knowledge and skills among community members.



A newly trained SMAG trainer teaches community members from Lundazi how to avoid delays in seeking care during recent safe motherhood training.

7.6 Safe Motherhood Action Group Swings into Action

Memory (not her real name) suddenly woke up with a sharp pain in her lower back and abdomen. She tried to sit up but the pain was so unbearable that she cried out to her husband, “Wake up! Help me please! I am in pain!” It suddenly dawned on Memory that she was in labor. “Go and call Ambuya quickly, I think the baby is coming!”

Memory is a young village girl who has been expecting her first child. For the past nine months, Memory had been very anxious and excited to be a mother. Her grandmother and aunt decided that Memory would deliver her baby at home just as her mother had done with all her children but little did they know that Memory’s baby was lying in an abnormal position.

Twenty-six hours later, they gave up and decided to take Memory to the nearest hospital but it was too late. Memory’s baby died due to lack of oxygen as a result of prolonged labor. Although Memory lost her baby, she is lucky to be alive. Thousands of women in rural Zambia have lost their lives during child birth, a situation that can be avoided.

Nyimba district of the Eastern Province is one such example where communities were faced with challenges related to mothers and babies dying during pregnancy, child birth and during the post-natal period.

The major contributing factors to maternal and newborn mortality included delays in decision making about taking the pregnant woman to the health center, pregnant women not wanting to go the health center for delivery and using traditional oxytocin on the onset of labor, and lack of transport or transport money to get to the health center.

The Ministry of Health (MOH) with support from the USAID-funded Zambia Integrated Systems Strengthening Program (ZISSP) introduced an initiative called, “Saving Mothers Giving Life” (SMGL) in Nyimba district, which recognizes communities as a major resource in safe motherhood sensitization activities.

Under the SMGL, the Eastern Provincial Health Office and the Nyimba District Health Office (DHO) in partnership with ZISSP, identified and trained 80 SMAG members from communities surrounding four health centers in Chinambi, Mkopeka, Hofmeyr and Chipembi. SMAG members were selected from each of the Neighborhood Health Committees of the four target health centers.

After receiving the training, the SMAG members were expected to mobilize communities and provide them with information on safe motherhood and newborn care. The SMAG members were also trained to collect and retain information and report on their activities to the health center. Equipped with knowledge from the training, SMAG members briefed the village headmen and the chiefs on the SMAG activities. From the start, SMAGs received political support from the local leadership who recognized the need for reducing maternal mortality in their communities.

A visit to Mkopeka and Chipembi health centers by the DHO team revealed that SMAG members had initiated community meetings on safe motherhood. Using the “Take Action Cards” and role plays during these community meetings, SMAG members were able to effectively reach community members of all

literacy levels to sensitize and educate them on safe motherhood. SMAG members could also identify and refer clients to the health centers, demonstrated by an increased number of referrals to the health centers, particularly in Chipembi and Mkopeka. The SMAG members are now getting support from local traditional leaders who also attend the community meetings.

Communities have observed an increase in the number of pregnant women who better understand safe motherhood practices and take action to deliver at a health center.

7.7 The Power Of Human Resources Training



Michael Sinkala, a Lecturer at National Institute for Public Administration, addressing the participants of the Management Leadership Academy training.

Smart Malama, an Assistant Human Resource Development Officer at Mansa General Hospital, has for the past 14 years faced numerous problems in handling staff problems and complaints at the hospital in a timely manner. The seemingly endless staff demands caused great stress for Smart and his colleagues in the department.

Although Smart is a qualified Assistant Human Resource Development Officer, he has not had the opportunity until now for hands-on training in administrative skills, which could have helped him effectively handle staff problems.

The case of Smart and many others prompted the Ministry of Health (MOH), with support from the USAID-funded Zambia Integrated Systems Strengthening Program (ZISSP) and BroachReach Institute for Training and Education (BRITE), to develop the Zambia Management Leadership Academic (ZMLA) Program in an effort to conduct management and leadership training for health care professionals countrywide.

The ZMLA training was conducted in Luapula Province where the staff was trained as part of the ZMLA cohort 17 in February 2012. The training was designed to equip health care professionals with the knowledge and skills to improve the delivery of health care in health facilities and to teach critical management and leadership skills for health care professionals to build and strengthen the capacity of local health systems.

Smart was among the participants in cohort 18, which was conducted in Mansa district. The training included human resources issues such as the critical path to estimate optimal time needed to completely address problems. This will ensure that a worker's problems are dealt with on time.

Soon after the training, Smart proudly explained, "After 14 years of working in the hospital, I am now able to clearly understand any problem presented by health care professionals as I have learned all about

strategic planning and problem solving tools such as atomization and the PESTLE framework to get to the root cause of the problem. I can now share the skills I have learned with my coworkers.”



A group of participants working on a case study.

The biggest lesson for Smart and his co-workers in the Human Resource Department was that, with timely management of human resources issues, health care professionals can be a motivated workforce who are able to deliver quality health services. With a motivated workforce, the hospital can meet its planned service delivery objectives.

The joint efforts by MOH and ZISSP to strengthen the capacity of managers at all levels will enable the managers perform their management functions effectively and eventually improve health delivery services across Zambia.

7.8 Pre-Performance Assessment Meetings Improve Capacity for the Southern Provincial Health Office Staff to Conduct District Performance Assessments and Report Findings

Performance assessments (PAs) are conducted biannually to evaluate the performance of the various district and health facility -level health programs against national standards and monitor progress towards meeting these set standards. PAs also enable the comparison of health program performance between districts and health facilities at the same level. Typically, Provincial Health Office (PHO) staff conduct PAs without first meeting to review the process, discuss previous PA findings, and plan for the upcoming PA. As a result, it is difficult for the PHO staff conducting the PA to be focused in their approach to address issues without an insight to the previous PA findings. Other challenges exist, including a lack of integrating previous PA findings into the current PA and for new program officers who are not acquainted with the PA process. What remains, is the need to have one common approach to conducting a PA and writing the PA report.

To address these challenges, the USAID-funded Zambia Integrated Systems Strengthening Program (ZISSP) worked through Management Specialists and Clinical Care Specialists seconded to the Southern Province to organize three pre-PA meetings to discuss past PA findings and plan for the next assessment. The meetings also provided a forum to address the need for a standardized method of collecting and reporting information.

The first pre-PA meeting was held to discuss data, performance, and the status of the consolidated reports from all the districts in Southern Province. Since it was clear that PAs were not conducted in a consistent manner, the PHO program staff was oriented to the PA guidelines and a common approach. This meeting was also used for staff to troubleshoot problems they encountered at the facilities during the PA process, such as facility staff not completing the PA tool or HMIS self-assessment, poor



understanding of PA indicators, and shortage and high turnover of facility staff trained to fill out the PA tool. The second meeting was to review and reinforce the information provided in the first meeting and discuss program indicators in detail. In the third meeting participants planned and prepared for the upcoming PA.

The staff at the southern PHO appreciated these meetings and believe that PA has improved tremendously as evidenced by the quality and timely reports that are now being submitted. Mrs. Nkatya, the Senior Health Education Officer from the Southern Provincial Health Office (PHO) explained, “I found these meetings to be very educative and interactive. They should be continued . . . it helps the teams to be focused as they go for PA as well as helps the team to

understand the indicators in the PA tool.” At the first meeting it was reported that only 22 PA reports were drafted (although not completed) from the assessed 51 health facilities, training institutions, and District Health Offices in the province. Individual reports for health centers assessed were not written at all. This meant none of the assessed levels had received feedback on the assessment. By the second meeting, all but two health centers completed PA reports by PHO. At the last meeting all 51 reports were completed according to the agreed upon standard and sent to the assessed sites.

Since the initiation of these meetings, the Southern PHO has witnessed progressive improvement in the way PA is conducted and how the reports are generated. ZISSP plans to continue to support such efforts in Southern Province and use this as a model for application in other provinces where similar PA challenges exist.

ANNEX A: ZISSP Achievements – June 2010 to March 2012 and January 1, 2012 to March 31, 2012

Indicator	Life of project (LOP)	Work Plan			Quarterly Achievements (Jan–Mar 12)			
	Targets (June 10 – June 14)	Achievements June 10 – Mar 12)			Targets (Oct 2011– Sept 2012)	Male	Female	Total
		Male	Female	Total				
Evidence that the MOH identifies, adopts, and/or implements policy, guideline, procedure, or system changes needed to achieve its strategic health plans (with USG support) ⁱ								
Number of improvements to laws, policies, regulations or guidelines to improve access to, quality of and utilization of health services drafted with USG support.	N/A			12 ⁱⁱ	N/A			8
Evidence that updated program manuals, clinical guidelines, protocols, and training curricula are in place and in use for specific high-impact service areas (FP, EmONC, CHN, Malaria). ⁱⁱⁱ								
Malaria incidence in selected districts.	97 per 1,000			356 per 1,000	208 per 1,000			356 per 1,000
Proportion of ZISSP target districts that routinely monitor district action plans and revise activities and budgets to reflect performance and resources.	100%			N/A	80%			0 (new indicator – monitoring just beginning)
Number of health care workers that successfully complete an in-service training program within the reporting period (management and leadership, planning, HR –PMP, data quality by gender) **HSS**	2,500	419	471	957 consists of MLA (331), Planning (90), Data Quality (100), Performance Management Package (436)	1,200	119	52	171
Proportion of MLA participants enrolled for one year that complete all 4 training sessions.	720	0	0	0	360	0	0	0
Number of ZISSP districts that have functional Clinical Care Teams.	27			9	10			9
Number of health care workers that successfully complete an in-service training program within the reporting period.	3,000 ^{iv} (COP target to Sept 2012)	713	598	1,505 ^v 883 (1,311 unique individuals)	2,400	422	389	883 (811 unique individuals)

Number of health care workers trained in family planning and reproductive health with USG funds.	400	23 (18 health care provider) (5 Nurse Tutors)	42 (19 health care providers) (23 Nurse Tutors)	65 (37 health care providers (28 Nurse Tutors)	80	0	0	0
Number of community volunteers trained in family planning and reproductive health with USG funds ^{vi}	540	0	0	0	120	0	0	0
Evidence of progress toward implementation of the Adolescent Health strategy and standards in ZISSP target districts. ^{vii}	N/A							
Number of health workers trained in maternal/newborn health through USG supported programs (EmONC) ^{viii}	540	84	132	216 (180 EmONC, 16 SMAG master trainers, 20 SMAG trainers)	120	30 (15 EmONC, 15 SMAG master trainers and trainers)	47 (26 EmONC, 21 SMAG master trainers and trainers)	41
Number of community volunteers trained in maternal/newborn health through USG supported programs (Safe Motherhood)	3,000	170	203	373 ^{ix}	920	110	118	228
Number of health care providers trained in child health and nutrition through USG-programs.	432	292	305	597	96	88	86	174
Number of community volunteers trained in child health and nutrition through USG-programs. ^x	TBD	151	172	323	120	64	85	149
Number of children under 12 months of age who received DPT3 from USG-supported program.	2,047,000			836,948	398,000			324,948
Number of children under 5 years of age who received Vitamin A from USG-supported programs.	TBD			1,785,000 (as of Nov 2011)	2,383,000			Data will be ready in Oct 2012
Number of people trained with USG funds to deliver IRS.	7,271	3,200	1,470	4,670 ^{xi}	915 ^{xii}	N/A	N/A	Data will be ready in Oct 2012
Number of houses targeted for spraying with IRS with USG funds	3,413,755			N/A	1,054,740			N/A
Number of houses sprayed with IRS with USG funds.	N/A			2,018,631	N/A			916,293 (87%)
Total number of residents of sprayed houses	15,959,305			7,759,324	4,930,910			3,809,102
Number of health workers trained in IPTp (FANC) with USG funds	1,656	30	48	78	360	16	24	40

Number of people trained in community case management (ICCM) with ACTs with USG funds	1,512	128	21	149 ^{xiii}	540	20	21	41
Evidence of improvements to systems and processes related to community engagement in health planning ^{xiv}	N/A							
Number of people trained in BCC/IEC methods or materials in ZISSP target districts	TBD			0	TBD			0

ⁱ This indicator is measured qualitatively

ⁱⁱ Clinical guidelines or training curriculum and materials have been revised or developed for: Community Based Distributors of Family Planning Methods, Zambia Management and Leadership Academy, mentoring training package, Quality improvement guidelines and training package, 6 different Planning Guidelines for specific types of MOH institution, National Resource Tracking Tool and Resource Tracking Tool.

ⁱⁱⁱ This indicator is measured qualitatively

^{iv} The target of 3,000 is based on the COP target of September 2012 and will carry the project to September 2012

^v Total number of mentorship sessions in FY 2011 was 622, while in FY 2012, ZISSP completed 883 mentoring sessions as of March 2012

^{vi} There was a delay in the finalization of the training materials by Ministry of Health. The materials were just finalized in early 2012.

^{vii} This indicator is measured qualitatively

^{viii} Total number 58 health care providers were trained in FY 2011, while as of March FY 2012, 122 health care providers were trained. 16 master trainers and 20 trainers for SMAGS were also trained in as March FY 2012. Specific to period of January to March 2012, a total of 41 health care providers were trained while

^{ix} Total number of SMAG trained as March 2012 is 373 which consist of 228 from the *4Saving Mothers Giving Life* District and 135 in other districts. However, it should be noted that among 135 SMAGs trained, 50 SMAG members were trained in Mansa and this before the SMGL project started.

^x Total of 174 community volunteers were trained in FY 11, while 149 community volunteers were trained from January – March 2012. However, it should be noted that no training for community health volunteers was done between Oct – Dec 2011.

^{xi} The figure includes sprayers trained in July – September 2010 (2,205) and July – September 2011(1,888) spraying period.

^{xii} The target has been adjusted from 2,060 to 915 number of people to be trained to deliver IRS because MOH and PMI have selected 20 districts for PMI IRS support rather than the previous 35 districts

^{xiii} This data does not include the data for October – December 2011 as it is still under verification but it includes FY 2011 and January – March 2012 and

^{xiv} This indicator is measured qualitatively