

# TRANSITIONING ZPCT II BRIDGE PROJECT PROGRAM ELEMENTS TO GRZ MANAGEMENT:

## A ROADMAP FOR THE FUTURE



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## List of Abbreviations

ADCH	Arthur Davison Children's Hospital
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
BOQs	Bill of Quantities
PMTCT	Prevention of Mother To Child Transmission
CCO	Clinical Care Officer
CDC	Centers for Disease Control
CHAI	Clinton Health Access Initiative
CHAZ	Churches Health Association of Zambia
CHWs	Community Health Workers
CoAg	Cooperative Agreements
CPOs	Community Purchase Orders
CT	Counselling and Testing
CVs	Community Volunteers
DECs	Data Entry Clerks
D-SERVE	District Service Delivery
DBS	Dry Blood Spot
DCMO	District Community Medical Offices
DHIOs	District Health Information Officers
DTC	Drug Therapeutic Committees
EID	Early Infant Diagnosis
eMTCT	Elimination of Mother To Child Transmission
EMS	Express Mail Service
EQA	External Quality Assurance
FOGs	Fixed Obligation Grants
GRZ	Government Republic of Zambia

HCC	Hospital Clinical Care
HCT	HIV Counseling and Testing
HIV	Human Immune Virus
HR	Human Resources
IT	Internet Technology
LOE	Level of Effort
LOP	Life of Project
MOH	Ministry of Health
MCDMCH	Ministry of Community Development, Mother and Child Health
MOW	Ministry of Works
NO	Nursing Officer
PA	Performance Assessment
PCR	Polymerase Chain Reaction
PIO	Provincial Infrastructure Officer
PICTO	Provincial Information Communication Technology Officer
PMEO	Provincial Medical Equipment Officer
PMO	Provincial Medical Office
SOPs	Standard Operating Procedures
SRS	Sample Referral System
TA	Technical Assistance
TOT	Trainer of Trainers
TSS	Technical Support Supervision
QA	Quality Assurance
QI	Quality Improvement
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VMMC.	Voluntary Medical Male Circumcision
WHO	World Health Organization

ZABS	Zambia Bureau of Standards
ZAMRA	Zambia Medicines Regulatory Authority
ZPCT	Zambia Prevention, Care and Treatment

## Foreword

Since 2005, the ZPCT I, ZPCT II, and now the Zambia Prevention Care and Treatment Partnership II Bridge (ZPCT IIB) project has supported the Government of the Republic of Zambia (GRZ) to scale up and strengthen comprehensive HIV and AIDS services to significant levels of coverage, access and quality in the targeted provinces and districts. These projects have been supported by USAID and PEPFAR and have provided essential support to the GRZ's response to the HIV/AIDS epidemic. The work has literally impacted the lives of millions of Zambians and has left the health system stronger.

As we go forward, the GRZ recognizes the need to transition the national response to our HIV/epidemic from donor support to increasing levels of GRZ support. While this transition is inevitable, the execution of the process needs to be done thoughtfully to avoid disruption and assure that the investments made over the last decade are sustained in ways that continue to meet the needs of the Zambian people. We congratulate FHI360 and their partners for their work in each of these projects, and appreciate their proactive effort to advance the necessary planning to assure that the various project elements now supported through the ZPCT II Bridge project are effectively transitioned to the Government of Zambia in the years to come. The recent meeting in Chaminuka organized by the USAID-supported ZPCT II B project provided an important opportunity for both the Ministry of Health (MOH) and the Ministry of Community Development and Mother and Child Health (MCDMCH) to consider how best to transition from project support for clinical HIV/AIDS services in the 6 northern provinces of Zambia: Central, Copperbelt, Northwestern, Luapula, Northern and Muchinga to GRZ support.

The discussions in Chaminuka, and the plan generated, provide a useful roadmap for both the ZPCT II B project, and any follow on project supported by USAID/PEPFAR, to transition from donor support to greater levels of government financing. The plan also highlights the specific program elements to be transitioned to government, the cost of implementing the program elements, capacity gaps and institutional readiness (incentives, structures, procedures) to ensure the successful implementation of the transition plan.

The plan generated at Chaminuka is not an end in itself; additional dialogue and consultation among all concerned parties will be needed to periodically review and monitor progress of the transition plan. Both ministries are committed to this process and to ensuring that the transition is a success.

Permanent Secretary, MOH

Date



Permanent Secretary, MCDMCH

Date



## Introduction

### Vision and scope of this plan

Over the past decade USAID has made important and significant contributions to the HIV/AIDS response in Zambia through the ZPCT and other projects. This began with a rapid mobilization of resources to respond to a major public health emergency, and has over the past decade shifted to a well-managed system of widespread evidence-based services that meets a significant proportion of the populations' needs. The task now is to ensure the quality and sustainability of these services. According to PEPFAR guidance, this means helping country stakeholders to lead, manage, coordinate, implement and over time and where appropriate – increasingly finance the national response while sustaining programmatic quality and coverage goals.<sup>1</sup>

This transition plan lays out strategies for how and when different elements of the ZPCT project could be transitioned to the GRZ. This strategic plan was designed with national, provincial and district representatives of the GRZ, but is considered a “living strategy” that will need to be regularly revised and jointly managed by a committed team from the GRZ and project.

This plan encompasses all major project elements of ZPCT II. For each of these project elements, the timeframes and approaches needed to transition them differ significantly. Some transitions will happen during the ZPCT II Bridge project, others in the early years of the D-SERVE project, many by the end of D-SERVE, and some may carry-on after D-SERVE. While planning that far into the future is limited, it was important to begin to think through the complete transition for each project element, to help set the right direction for medium term actions and accomplishments.

#### **Text box 1: Major ZPCT II project elements:**

- 1) Training service providers for HIV/AIDS service delivery
- 2) Supportive supervision and clinical mentoring in HIV/AIDS technical areas
- 3) Tools for measuring and monitoring the quality of HIV/AIDS services
- 4) Strengthening laboratories for HIV/AIDS related testing
- 5) Strengthening commodity management and ensuring uninterrupted stocks for HIV/AIDS services
- 6) IT TA Support and equipment for information systems
- 7) Training, placing, and supporting community volunteers to support HIV/AIDS services
- 8) Human resource management – DECs
- 9) Facility renovations

### Approach for the transition planning

To develop this transition plan, the ZPCT team identified its major program elements (where money is spent), developed complete descriptions of these (including costing the activities), identified related activities and initiatives of the GRZ, discussed opportunities and barriers to the transition, developed ideas about how they could be transitioned to the GRZ, and then shared, discussed, and reworked these ideas with the MOH and MCDMCH to develop the specifics in this plan.

### Implementing/managing the Plan

ZPCT and the line ministries responsible for health will form a transitioning task team with high level representation from both ministries and project staff. The task team will be responsible for monitoring the performance of the plan on quarterly basis and make revisions as need arises, and communicate the

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<sup>1</sup> FY 2014 PEPFAR guidance for sustainability planning, October 2013

progress of the plan to the wider Technical Working Group at the Ministry of Health. This plan serves as a bridge between ZPCT II Bridge and D-SERVE.

## Transition plans for ZPCT II program elements

### Program Area 1: Training service providers for HIV/AIDS service delivery

#### ZPCT's role in in-service training

Under the in-service training program area, ZPCT provides support to target provinces, districts and health facilities to build capacity of health care workers (HCWs) through in-service trainings in the following key areas: counselling and testing, provision of PMTCT, ART, male circumcision, and laboratory services. For in-service trainings in these areas, the project still plays a major role in identifying training needs, organizing trainings, monitoring and documenting trainings, providing follow-up TA to trainees, paying for trainings, and managing the funding for trainings (see Appendix B for details on the management tasks implemented by ZPCT). A total of USD\$223,873 was spent on in-service trainings over the five years of ZPCT II, resulting in 10,613 training participants over that period. This support in trainings resulted in improved health worker skills to effectively deliver HIV/AIDS services to clients.

#### Proposed transition strategy and timeframe

ZPCT's proposed strategy for transitioning some of the key elements of this program over the next five years(?) will be to: 1) begin utilizing the GRZ system to identify training needs and participants; 2) establish rigorous procedures within GRZ for quality assurance and accountability; and, 3) if necessary conditions are met, provide transitional funding for trainings using either fixed-price contracts or fixed-obligation grants. As a robust and accountable system gets institutionalized, the project will begin to negotiate for gradual reduction in donor funding. In addition, the project will negotiate and facilitate phasing many training topics into pre-service trainings to reduce the number of in-service trainings needed. Currently ZPCT uses GRZ training manuals and trainers for most of the trainings except specialized ones, therefore it is possible that GRZ is capable of organizing and managing HIV/AIDS related trainings once funding is made available to them, and a rigorous accountability and quality assurance mechanism were put in place. (see Appendix B)

Some key milestones for the transition:

- By the end of the first quarter of FY15, the project and GRZ will agree on in-service training transition indicators and targets, and a specific action plan for capacity building and systems strengthening interventions.
- By the beginning of FY16, a selection of at least 6 districts will meet the conditions for and begin receiving project funding to them to independently manage and implement in-service trainings for HIV/AIDS services
- By the end of FY19, all but a few districts will meet the conditions for and begin receiving project funding for trainings
- By the end of FY 20, a plan will be agreed for a phase-out of donor funding for these in-service trainings

## Program Area 2: Providing clinical mentoring and supportive supervision in PMTCT, clinical care/ART, and MC.

### ZPCT's role in clinical mentoring and supportive supervision

ZPCT provides post training follow-up visits and on site mentorship activities quarterly, based on performance data and previous quarterly mentoring reports. During supportive visits, ZPCT staff with their government counterparts check quality of service delivery using defined tools for measuring performance; identify support needs; supply job aids; and disseminate national guidelines and protocols. ZPCT mentors document needs which are either followed-up in the next visit or communicated to the relevant ZPCT II unit to address.

At provincial level, ZPCT staff participate in HIV/AIDS related clinical meetings, data review meetings and case studies. In addition, the Provincial ZPCT technical staff participate in monthly data review meetings with the districts. The meetings review service statistics as a way of monitoring program performance, identifying gaps in service provision as well as identifying remedial actions. The project has also established two model sites in each province. These are sites that have highly trained and experienced health care workers who mentor health care workers from other health facilities in the district. Health care workers from poorly performing sites in the province go to the model sites to learn through demonstration and week-long attachments.

To support these activities, the project pays for transportation, per diem, salaries of mentors, materials such as forms, tools, guidelines and support for clinical meetings. During the five years of ZPCT II, the project spent a total of US\$270,000 for clinical mentoring and supportive supervision visits, resulting in regular support for 407 health centers and 43 hospitals.

### Proposed transition strategy and timeframe

To transition ZPCT mentoring activities in PMTCT, clinical care/ART, and voluntary medical male circumcision, the proposed strategy would be to collaborate with GRZ to disseminate and implement HIV related guidelines, protocols and standards. In addition the project will support GRZ to create a pool of trained frontline providers and supervisors/managers from government institutions with strengthened skills in clinical mentoring to support mentoring for key program elements—PMTCT, clinical care/ART, and MC—into the GRZ system. Further, the project will work with Provincial Medical Offices to establish technical certifications for clinical mentors in PMTCT, clinical care/ART and VMMC.

Capacity building activities to ensure effective transition in this area will also include orientation in mentorship skills, training in respective technical areas for those that require this, joint planning and supervisory visits to the facilities. In addition, the project will also strengthen DCMO and hospitals competencies to manage mentorship activities using the Clinical Care Teams, ensuring the right mix of cadres, numbers and competencies. The project will also facilitate joint monthly review meetings and integrate mentorship visits into existing GRZ supervisory visits such as Performance Assessment (PA) and Technical Support (TSS) visits conducted bi-annually. In terms of financing, the project will work with GRZ to plan and to leverage resources between GRZ, ZPCT and other stakeholders. As a transitional financing strategy, Fixed Obligation Grants (FOGs)/CPOs arrangement is being proposed. If GRZ is agreeable and once the model has been fully institutionalized, USG and GRZ will negotiate a timeline to gradually reduce

donor funding. In addition, the proposal is to initially start with one district per Province, and once the model is refined and proven, it will then be expanded to other remaining districts

Specific transition activities to happen during the ZPCT II Bridge:

- Assess existing district & provincial mentoring functions and capacities
- Pilot joint structured mentoring with GRZ in at least one district/province using tools for documentation & follow up
- Establish technical certifications for clinical mentors in PMTCT, clinical care/ART, and VMMC
- Work with GRZ to plan the integration of the model sites approach into the government clinical mentoring system
- Disseminate revised tools which integrate monitoring for HIV indicators
- Conduct TOT for key GRZ staff in supervisory/managerial positions and strategic resource persons in various disciplines
- Conduct joint mentoring to facilities with newly trained mentors
- Support six districts to cover HIV/AIDS mentoring in their planning and review meetings

### Program Area 3: Using tools for measuring and monitoring the quality of HIV/AIDS services (QA/QI)

ZPCT's role in QA/QI for HIV/AIDS services

ZPCT IIB uses QA/QI tools to assess & enforce national standards. The project has been involved in developing and updating QI/QA tools based on nationally approved Standard Operating Procedures (SOPs). Healthcare workers in ZPCT supported sites have been trained to implement QI/QA using GRZ trainers and MOH training manuals. Using QA/QI tools, quality improvement problems are identified and action plans are developed to resolve identified issues. As part of efforts to institutionalize QA/QI, ZPCT supported the formation of facility-based QI committees and have continued to support monthly/quarterly meetings. In addition, ZPCT has continued to maintain the QA/QI electronic database on behalf of GRZ. This program is undertaken alongside clinical mentoring activities and uses the same budget (\$744,000) per annum.

Proposed transition strategy and timeframe

To transition ZPCT support for QA/QI the general strategy would be to align the program with the national QI structures that is, integrate the ZPCT QI program into the national QI program and the QA program into the mentorship program which districts would be implementing. Other strategies will be to strengthen QA/QI at implementation level through training of HCW in QA/QI, facilitate appropriate support to ensure active QI committees, and facilitate implementation of QI projects at facility level; i.e. support facility monthly meetings so that facility staff are able to identify & implement QI projects and track QI indicators. The project will continue to strengthen monitoring of national QI indicators related to HIV/AIDS and will provide additional support to GRZ to institutionalize QA/QI program in their health institutions. At PMO, the project will place an individual such as a Clinical Care Specialist to oversee and coordinate QA/QI activities as part of systems strengthening efforts.

Suggested ideas for financing strategy include putting money in recipient agreements for the PMOs, DCMOs & facilities and sharing budgets and resources through a defined and approved process by GRZ counterparts.

Some key milestones for the transition:

- By FY16, ZPCT QI structures will be aligned with and integrated into national QI program
- By FY17, the ZPCT QA Tools will be aligned with and integrated into national QI program tools

Specific transition activities to happen during the ZPCT II Bridge:

- Identify which districts and facilities have functional QI committees
- Support establishment of QI committees in districts & facilities
- Provide support to selected committees to hold meetings
- ZPCT to participate in MOH review process of the PA tools to incorporate ZPCT tools for monitoring HIV services (PMTCT, ART, VMMC)
- Conduct refresher trainings in rational use of the QA/QI tools for district /HCWs
- To support HCWS to conduct self-assessment using QA/QI tools
- Conduct training in QI using national QI training package and provincial trainee
- Conduct joint TSS and mentorship in QI in new and old facilities and agree on criteria for graduated facilities/districts.

#### Program Area 4: Strengthening laboratories for HIV/AIDS related testing

##### ZPCT's role in strengthening laboratories

ZPCT II has procured high value laboratory equipment in 131 laboratories at a cost of \$2,237,960 and procured low value laboratory equipment in 167 laboratories at a cost of \$717,000 over five years. Specific interventions include the maintenance of laboratory equipment (K750,000/year) and paying staff salaries at Ndola PCR laboratory at a cost of \$83,000 per year, procurement of equipment for the PCR laboratory at a cost of USD\$279,985 over a period of five years. The project also undertook renovations in 143 laboratories in the past five years where \$1,032,000 has been spent.

As part of capacity building and sustainability efforts, the project supports 3 day trainings perquarter for laboratory staff in equipment use and maintenance per province where \$145,000 has so far been spent over a period of five years. In addition, the project also has supported trainings and mentorship programs in commodity management for Pharmacy staff at a cost of over \$145,000 over aperiod of five years. ZPCT also has established a CD4 sample referral system and supported procurement of motorcycles and operational costs to the tune of \$890,000 over a five year period. The project continues to manage the system for identifying needs and procuring equipment.

##### Proposed transition strategy and timeframe

In the next five years through the life span of D-SERVE, the project will collaborate with GRZ counterparts in planning and budgeting for GRZ to increase budget allocation towards procurement of high and low value laboratory equipment, and development of a fully sustained equipment service and maintenance plan where GRZ will take a lead, with limited partner support.

In addition, the project will continue to work with GRZ to build capacity of provinces in equipment use and maintenance so that by the end of the project the process is fully managed by the Provincial Medical Equipment Officer through District Biomedical Equipment Engineers. GRZ is currently training 27 District Biomedical Engineers. The project will also continue to lobby for placement of full time GRZ staff at ADCH PCR Laboratory in Ndola.

Potential support areas necessary for smooth transitioning required to be undertaken by the project include: training Provincial Medical Equipment Officer in laboratory equipment maintenance and repair; extending the pharmacy mentorship programs to laboratory staff at district level to enhance good commodity management practices; and, expanding supervision activities in commodity management skills and knowledge to other health professionals to maximize technical assistance impact. In addition, the project should consider supporting the training of more District Biomedical Equipment Engineers, procurement of more motorcycles for CD4 sample referral system and replacement of obsolete laboratory equipment.

Some key transition milestones:

- By FY18, the ADCH PCR laboratory will be fully managed by GRZ
- By FY16, GRZ will have developed an equipment service and maintenance plan for PCR laboratories
- By FY18, equipment maintenance, service and repair will be fully managed by PMOs and DCMOs
- By FY19, Laboratory Equipment Standards will be adopted by GRZ and integrated into ZABS
- By FY19, the procurement of most high value and low value laboratory equipment will be financed by GRZ

Specific transition activities to happen during the ZPCT II Bridge:

- The project will help PMOs and DCMOs budget for equipment servicing and repairs of motorbikes and airconditioners.
- The project will lobby for the GRZ to recruit and place GRZ officers at ADCH PCR laboratory

### Program Area 5: Strengthening commodity management and ensuring uninterrupted stocks for HIV/AIDS services\*

ZPCT's role in strengthening commodity management

ZPCT II support to commodity management for HIV/AIDS is meant to ensure effective and enhanced commodity management with a focus on commodity availability in support of HIV/AIDS service delivery. Support the project provides includes: 1) procuring pharmacy support equipment; 2) refurbishing and renovating pharmacy store rooms and dispensaries; 3) procuring commodities to support voluntary medical male circumcision (VMMC) services; 4) supporting the regular Drugs and Therapeutics Committee meetings in ZPCT supported districts; 5) printing pharmacy refill prescriptions for facilities; 6) providing commodity management trainings; 7) participating in the periodic revision of Pharmacy standard operating procedures (SOPs); and 8) disseminating pharmacy SOPs. See Appendix F for more details on these activities. ZPCT strengthens pharmacy services in all its 450 supported facilities has spent approximately USD\$1,321,349 in the last five years in this program area.

### Proposed transition strategy and timeframe

As a strategy for transitioning some of the program elements into GRZ management system, the project will engage GRZ to lobby for incremental allocation of financial resources in their action plans for procurement of basic equipment and replacement of malfunctioning or obsolete equipment. In addition, the project will also engage provincial and district pharmacists to plan and budget for equipment repairs and servicing. To ensure sustainability of quality and standards, the project will begin the process of incorporating the pharmacy mentorship program in provincial/district action plans and advocate for funding from EU, WHO, and other stakeholders to implement and roll out the program. The project will also facilitate the regular review and updating of guidelines, SOPs and work with GRZ to ensure that these are included in GRZ plans and budgets. To ensure stocks are equitably distributed and made available in all sites, ZPCT will strengthen the holding of regular review of the GRZ pipeline and supply chain management tool and support implementation of a robust redistribution subsystem. To avoid management of parallel logistic systems, the project will support the implementation and roll out of the national MC logistics system into the existing national logistics systems. While the project will continue to provide funding for key elements of commodity management, efforts will be made to influence the funding of selected sub-elements.

Some key transition milestones:

- By FY18, GRZ will increase its budget support for procurement and maintenance of pharmacy support equipment by 20%
- By the end of FY18, the MC logistics system will be integrated into the national logistics system
- By the end of FY18, the Pharmacy mentorship program will be integrated into provincial/district action plans

Specific transition activities to happen during the ZPCT II Bridge:

- ZPCT II B to conduct quarterly joint visits with the provincial pharmacist, district pharmacist and Provincial Medical Equipment Officer to provide technical assistance and monitor equipment functionality, and determine repair and servicing needs
- Engagement of GRZ Officers at all levels for consultative action plans for equipment repairs and servicing and to validate transition strategies.
- Support implementation and roll out of the national MC logistics system and incorporation into existing national logistics systems
- Explore use of Provincial Medical Officer motor vehicle service center for repair and servicing of motorcycles that are beyond warranty
- Creation of joint provincial database to capture and manage all equipment at provincial level by August 2015

### Program Area 6: Information Technology Technical Assistance Support and equipment for information systems

ZPCT's role in providing IT support

ZPCT IIB supports MOH/MCDMCH by procuring and supplying computers, printers, and UPSs to health facilities that use the SmartCare program for patient monitoring and continuity of care. The project also

provides IT technical support and maintenance of equipment. In addition, ZPCT staff conduct facility assessments to identify and prioritize sites needing computers and related equipment, upgrades and maintains equipment, and replaces obsolete equipment. The project also provides training and support to MOH staff in the use of SmartCare at facility level. To undertake these activities in this program area, ZPCT spent more than \$356,827 over the five years of ZPCT II.

#### Proposed transition strategy and timeframe

To transition ZPCT support for IT and information systems, the general strategy would be to decentralize this service to district level with supervision from provincial level. This could first be done by identifying and strengthening what GRZ is already doing or things which are contained in the GRZ ICT guidelines that are in line with what ZPCT is currently doing. This might be in the initial 10 districts and rolled out to the districts once proven to be successful and cost effective. To do this ZPCT will build capacity of MOH so that needs assessments will be done by them. In addition, ZPCT will procure the equipment as determined by MOH and trained MOH staff (i.e. PICTO/DHIO) will take the leading role in hardware network and software support. Capacity building will continue as needed. By the end of D-SERVE all support visits will be handled by PICTO/DHIO.

As funding strategy, the project will conduct joint planning activities with GRZ and begin to transfer some of the subelements of the program to GRZ for support. However, this is one component that will continue to depend on donor support for the foreseeable future.

Some key milestones:

- By the end of FY16, PICTO/DHIO take leading role in all IT assessment/planning for IT equipment and networking in supported facilities in 10 districts

#### Program Area 7: Training, placing, and supporting community volunteers to support HIV/AIDS services (CT lay counselors, PMTCT counselors, MMC counselors, and ART adherence support workers)

##### ZPCT's role in supporting community volunteers

ZPCT has supported the training and placement of 1,419 community volunteers in 400 MOH health facilities in six provinces. The volunteers provide direct services in HIV testing and counselling (HTC), elimination of Mother to Child Transmission (MTCT) counselling, Medical Male Circumcision (MMC) counselling and mobilisation; and Antiretroviral Treatment (ART) adherence counseling. The volunteers contribute 17,028 man hours which is equivalent to 774 health care workers. This is on assumption that health care workers work 22 days in a month. The volunteers also work in communities to create demand for HIV/AIDS services. In 2014 the volunteers motivated 887,650 clients to access various HIV/AIDS services and out of this 751,041 actually accessed the services. ZPCT staff collaborate with District Clinical Officers and facility staff to identify staffing gaps in health facilities with a view to fill the gaps with volunteers. Community volunteers are jointly identified, trained using MOH certified trainers and approved manuals, and placed at designated health facilities. ZPCT organizes and finances the training of the identified community members. The Clinical Care Officer at DCMO attends the training to verify the quality of the training by verifying that certified trainers are being used, the content and duration of the course conform to approved national training guidelines. Once trained the volunteers are placed at their designated health facility and each is provided with a stipend of \$30 per month.

### Proposed transition strategy and timeframe

The proposed strategy is for the project to lobby for recognition of the community volunteers in health service delivery as part of a coherent system of community volunteers; ie. their identification, training, supervision and remuneration. The project will advocate for the institutionalization of management of these cadres into GRZ procedures and guidelines by incorporating the supervision of these cadres into Environmental Health Technician's job description. In the interim, the project will explore providing transitional results-based financing to GRZ for management of these cadres, and once fully institutionalized begin to gradually transition the financing of these cadres away from the project to GRZ or other donors including direct financing from USG. Under D-SERVE management and support activities should be transitioned completely in one or a few districts to results-based grants.

Some key milestones:

- By the end of FY19, the project will give GRZ a report on a proven sustainable model for supporting community volunteers who are involved in task shifting in GRZ facilities.
- By the end of FY16, community level data collection, analysis and reporting will be integrated into the HMIS and/or SmartCare, as appropriate.
- By the end of FY17, EHTs will routinely supervise community volunteers in all 56 project supported districts.

### Program Area 8: Managing Data Entry Clerks (DECs)

#### ZPCT's role in supporting DECs program element

The ZPCT project has employed and supports 180 Data Entry Clerks (DECs) who are attached to 140 ZPCT supported health facilities in the six provinces. DECs collect and manage data which is analyzed, interpreted and used for improving HIV/AIDS program needs. The project trains and conducts refresher courses for DECs and provides mentorship in data management for HIV/AIDS services. Other support provided to the DECs include computers, stationary (registers and smart care forms), internet support, and filling cabinets. To manage the DECs, the project spends \$1,842,010 per year in form of salaries and fringe benefits.

### Proposed transition strategy and timeframe

The proposed strategy for transitioning DECs to GRZ is to engage GRZ by writing a concept note on DECs which should be submitted to Human Resource to advocate for inclusion of this cadre into the GRZ structure as they were very critical in the delivery of HIV/AIDS service. In addition, lobby for GRZ to train DECS as record clerks and employ DECs and M&E officer at high volume health facilities, district and provincial health offices. To strengthen the capacity of the DECs, the project will continue to conduct joint, trainings, supervisory and mentoring activities as well as joint M&E activities with DCMOs. The project will begin to leverage resources for the trainings as well as supportive/mentoring visits as a starting point for transitioning DECs to GRZ.

Some key milestones:

- By the end of FY16, GRZ officially includes the DECs in GRZ structure
- By FY19, 10% of DECs will be included on the GRZ payroll
- By 2022, 100% of DECs will be included on the GRZ payroll

## Program Area 9: Renovating facilities

### ZPCT's role in renovating facilities

ZPCT II Bridge works with MOH/MCDMCH to refurbish health facilities in order to provide conducive environment and adequate space for the provision of HIV/AIDS and other related services. The majority of the GRZ facilities in which ZPCT provides support have not been expanded proportionate to the increase in the number of people seeking HIV/AIDS services, thus necessitating major and minor renovations that include expansion of existing infrastructure. ZPCT coordinates with GRZ counterparts to conduct facility assessments, prioritize renovation needs, plan and contract for the renovations, and implement inspections with Environmental Health Technologists (EHTs)/MOW to ensure quality and adherence to specifications. ZPCT II refurbished 260 health facilities and 15 new construction works since 2009 in the 6 Northern provinces of Zambia at a total cost of K15,576,948. ZPCT IIB is currently in the process of refurbishing 16 additional facilities at an estimated cost of K1,277,737.

### Proposed transition strategy and timeframe

So far, there has been no integration of donor funded refurbishment processes with government systems. However, the project has liaised with MOH/MCDMCH in the tendering process by allowing the MOH to take the lead in advertising and evaluating tenders. The project currently develops the necessary BOQs, budgets and implementation plans, reviews and awards contracts and conducts inspections of works in collaboration MOW, as the custodian of all government buildings, to ensure quality and adherence to specification. It is envisioned that more involvement of the MOH will see MOH eventually taking over all these project functions. However the project will continue to provide funding for refurbishments. Capacity building areas required for post transition will be to strengthen capacity of PIOs to conduct feasibility assessments and estimation of costs; assessment of patient flow and infection control; production of standard architectural drawings, and BOQs using SMM7-PIO; training in donor rules and regulations for both DCMO/PIO, and contract administration and inspections for both EHTs/PIOs.

As part of transition the project will work with GRZ to ensure use of Firm fixed price contracts for new construction with fixed scope as well as hasten the process for variation contracts for any additional costs arising from unforeseen extra works (under refurbishments). In addition, there will be need to improve on confidentiality and follow government policy of non-disclosure of tender evaluation outcomes before contract award. In terms of transitional financing, there is currently no funded position for Provincial Infrastructure Officer under the GRZ establishment, therefore MOH will continue to utilize donor funds to continue supporting this position. Similarly there is no position of District Infrastructure Officer, which GRZ could consider creating and funding.

### Some key milestones:

- By the end of FY16, Provincial/District infrastructure point persons will be supervising, monitoring, inspecting and certifying works
- By the end of FY16, the donor funded refurbishment process will be partially implemented through GRZ systems
- By the end of 2020, the donor funded refurbishment process will be completely implemented through GRZ systems

## Appendix A: Transition plan summary overview

Project element	Key pieces	Absorption plan by GRZ	Milestones/measures of progress
Training Providers for HIV/AIDS delivery	<p><u>Inputs:</u> HR, Funding for training, Training materials, Transport &amp; fuel cost/lubricants, stationery.</p> <p><u>Activities/tasks:</u></p> <ul style="list-style-type: none"> <li>• Identification of training needs for HIV/AIDS service provision.</li> <li>• Produce and monitor training plans</li> <li>• Identify training participants.</li> <li>• Maintain training database</li> <li>• Conduct refresher training for trainers.</li> <li>• Conduct refresher training for health care workers</li> <li>• System of accountability for outputs</li> <li>• Hold regular partner meetings and engage partners to support these meetings</li> <li>• Coordinate and conduct training including adequate training documentation</li> <li>• Verify quality of training</li> <li>• Enforce financial regulations for training funds</li> <li>• GRZ to take the lead on inclusion of in service training in to the pre service curricula.</li> </ul>	<p><u>The institutions that will absorb activities:</u></p> <p><u>Procedures/guidelines/tools that will be changed:</u></p> <ul style="list-style-type: none"> <li>• Job aids and the training materials need to quickly reflect any recent policy changes in each subject area.</li> <li>• The procedure to update the training database needs to change to the donor so that training registration form is used to enter data into the database.</li> </ul> <p><u>Capacity strengthening:</u></p> <ul style="list-style-type: none"> <li>• Capacity building of districts on planning, financial management, and quality assurance for trainings.</li> <li>• Placement of Advisor at provincial to provide onsite capacity building activities.</li> <li>• Systematically identify and track training needs based on performance assessments and mentoring</li> <li>• Produce HR development/training plans (developed by district planner, DCMO, CCO, and NO, etc.)</li> <li>• Coordinate/organize trainings</li> <li>• Financial management (transportation allowance, etc), and proper documentation and reporting on activities</li> <li>• Verification of quality of training</li> </ul>	<ul style="list-style-type: none"> <li>• # districts with systems in place to manage funding &amp; trainings</li> <li>• # districts implementing trainings through grants/contracts</li> <li>• Value of USAID funding that has been transitioned</li> <li>• Value of GRZ contributions to HIV/AIDS trainings</li> <li>• # of participants trained</li> <li>• # Trainings / Refresher Courses Conducted</li> <li>• # Assessments undertaken</li> </ul>

		<ul style="list-style-type: none"> <li>• Strengthening the capacity of the Information officers and HR development officers to maintain training databases.</li> <li>• <u>Transitional financing:</u></li> <li>• Training would be paid for in the transition by donors while GRZ progressively took on more financial responsibilities for training</li> <li>• Engage GRZ to determine appropriate mechanism to finance the transition</li> <li>• Provision of transitional funding for trainings using either “fixed-price” or fixed-obligation” grants.</li> </ul>	
Provide clinical mentoring and supportive supervision in PMTCT, clinical care/ART, and MC	<p><u>Inputs:</u> HR, Training /supervisory tools, Finances, Transport , fuel costs/lubricants, certificates, stationery</p> <p><u>Activities/tasks:</u></p> <ul style="list-style-type: none"> <li>• Assessment of district/provincial mentoring functions capacities</li> <li>• Pilot joint structured mentoring with GRZ in at least one district/province using tools for documentation and follow-up</li> <li>• Integrate model sites approach into GRZ clinical mentoring system</li> <li>• TOT for key GRZstaff in supervisory/management positions</li> <li>• Establish technical certifications for clinical</li> </ul>	<p><u>The institutions that will absorb activities:</u> MOH/MCDMCH, other partners</p> <p><u>Procedures/guidelines/tools that will be changed:</u></p> <ul style="list-style-type: none"> <li>• Include ZPCT indicators in GRZ tools eg PA tools</li> <li>• Tools to reflect new guidelines</li> <li>• Review HIV parts of the tools</li> </ul> <p><u>Capacity strengthening:</u></p> <ul style="list-style-type: none"> <li>• Joint planning of activities between GRZ and ZPCT staff</li> <li>• Managing logistics and resources to conduct mentorship by GRZ</li> <li>• Joint visits</li> <li>• Strengthen competences at DCMO and hospital level to manage mentorship: Clinical care teams (Right mix of cadres, numbers and competences)</li> <li>• ZPCT needs to review its process of recipient agreements</li> <li>• Monthly meetings between programme officers (GRZ, ZPCT)</li> </ul>	<ul style="list-style-type: none"> <li>• # visits by clinical care teams</li> <li>• # of health care workers mentored</li> <li>• # of review meetings held between GRZ and project staff</li> <li>• Trip reports</li> <li>• increased retention</li> <li>• # joint planning meetings and visits</li> <li>• Number of indicators tracked(retention, uptake, access, quality)</li> <li>• # of functional clinical care teams</li> </ul>

	mentors in PMTCT, clinical care/ART, and VMMC	<ul style="list-style-type: none"> <li>Integrate mentorship visits</li> </ul> <u>Transitional financing:</u> <ul style="list-style-type: none"> <li>Initial stage of the transition joint planning to leverage resources from both GRZ, Project &amp; other stakeholders.</li> <li>Use of FOGs/FPCs with districts to support trainings.</li> </ul>	
Using Tools for measuring and monitoring the quality of HIV/AIDS services (QA/QI)	<u>Inputs:</u> HR, Training/mentoring tools, stationery, Transport, fuel costs/lubricants  <u>Activities/tasks:</u> <ul style="list-style-type: none"> <li>Establishment of QIQA committees in districts &amp; facilities</li> <li>Support holding of QA/QI meetings to selected committees</li> <li>Integrate ZPCT QA program into GRZ PA and mentorship program</li> <li>Refresher trainings in rational use of the QA/QI tools &amp; self-assessment</li> <li>Support trainings in mentorship</li> <li>Joint mentorship visits with GRZ &amp; stakeholders.</li> </ul>	<u>The institutions that will absorb activities:</u> MOH/MCDMCH, other partners  <u>Procedures/guidelines/tools that will be changed:</u> <ul style="list-style-type: none"> <li>Integration of ZPCT HIV/AIDS monitoring indicators into GRZ Performance Assessment tool</li> </ul> <u>Capacity strengthening:</u> Mentorship capacity <ul style="list-style-type: none"> <li>Refresher trainings &amp; trainings in mentorship</li> <li>Support joint mentorship visits</li> </ul> Joint planning <ul style="list-style-type: none"> <li>Support QI committees</li> <li>Support QI trainings</li> </ul> <u>Transitional financing:</u> <ul style="list-style-type: none"> <li>Put money in recipient agreements for the PMOs, DCMOs &amp; facilities to support QA/QI activities</li> <li>Joint planning to leverage resource from GRZ, project &amp; other stakeholders.</li> </ul>	<ul style="list-style-type: none"> <li># of functional QI Committees</li> <li># health facilities with QI projects</li> <li># of review meetings</li> <li># of joint QI support visits</li> <li>Proportion of districts actively implementing QI projects in selected facilities</li> </ul>
Strengthening laboratories for	<u>Inputs:</u> HR, Finances, Laboratory Equipment, training materials, stationery	<u>The institutions that will absorb activities:</u> MOH and other partners  <u>Procedures/guidelines/tools that will be changed:</u>	<ul style="list-style-type: none"> <li># of equipment serviced by GRZ identified vendor</li> </ul>

<p>HIV/AIDS related testing</p>	<p><u>Activities/tasks</u></p> <ul style="list-style-type: none"> <li>• Needs assessment and prioritization</li> <li>• Procurement high level &amp; lower level equipment</li> <li>• Equipment maintenance and repair</li> <li>• Development of equipment service and maintenance plan by GRZ</li> <li>• Integration of laboratory equipment standards based on Zambia Bureau of Standards (ZABS) by 2017 and regular calibration of equipment at ZABS</li> <li>• Training of laboratory staff</li> <li>• External quality assessments (EQA) for laboratory tests</li> <li>• Refurbishments/renovations for laboratories</li> <li>• Training of additional District Biomedical Equipment Engineers</li> <li>• Advocacy for recruitment/placement of GRZ officers at ADCH PCR laboratory</li> <li>• CD4 Sample Referral System (SRS)</li> </ul>	<ul style="list-style-type: none"> <li>• Equipment Branding should include GRZ and USAID logos</li> <li>• Consider branding to include warranty expiry date</li> <li>• Consider warranty management to be handled by Provincial Medical Equipment Officer and District Biomedical Equipment Engineer</li> </ul> <p><u>Capacity strengthening:</u></p> <ul style="list-style-type: none"> <li>• Training Provincial Medical Equipment Officer in laboratory equipment maintenance and repair beyond their current basic equipment maintenance skills.</li> <li>• Training GRZ staff in good commodity management practices.</li> <li>• Train more District Biomedical Equipment Engineers</li> <li>• Train district laboratory scientists</li> <li>• Procure more motorcycles for CD4 sample referral system.</li> <li>• Replace obsolete laboratory equipment</li> </ul> <p><u>Transitional financing</u></p> <ul style="list-style-type: none"> <li>• Continue to engaging MOH while emphasizing the phased approach of the transition over time.</li> <li>• Joint planning to ensure MOH begins to include and budget for few program activities at a time until the program is fully transitioned to GRZ.</li> </ul>	<ul style="list-style-type: none"> <li>• # of equipment being serviced by the PMEO and DBEE</li> <li>• # of districts with Biomedical Medical Equipment Engineers</li> <li>• # of districts reporting correctly and on time for lab commodities</li> <li>• Turn around time for equipment downtime</li> <li>• # DBS samples sent and results</li> <li>• # of full time staff deployed by GRZ at Ndola PCR lab</li> <li>• # of districts with functional specimen referral system</li> <li>• Proportion of GRZ budget committed to laboratory equipment maintenance (including PCR lab)</li> <li>• # of trained engineers capable of servicing and repairing major equipment platforms</li> </ul>
<p>Strengthening commodity management &amp; ensuring</p>	<p><u>Inputs:</u> HR, Finances, medical/non medical supplies, Equipment,SOPs, ART/laboratory commodities, MC</p>	<p><u>The institutions that will absorb activities:</u> MOH, MCDMCH, other Partners</p> <p><u>Procedures/guidelines/tools that will be changed:</u></p>	<ul style="list-style-type: none"> <li>• # of equipment procured for pharmacy departments by GRZ</li> </ul>

<p>uninterrupted stocks for HIV/AIDS services</p>	<p>commodities, Pharmacy Refill forms, stationery</p> <p><u>Activities/tasks:</u></p> <ul style="list-style-type: none"> <li>• Procuring equipment for pharmacy departments.</li> <li>• Pharmacy Refurbishments and renovations</li> <li>• Review of SOPs</li> <li>• Training HCWs in commodity management</li> <li>• Providing pharmacovigilance support.</li> <li>• Stop-gap procurement of ART and laboratory commodities to avoid stock-outs</li> <li>• Procuring male circumcision commodities</li> <li>• Support for DTCs</li> <li>• Providing Pharmacy Refill Forms</li> </ul>	<ul style="list-style-type: none"> <li>• Equipment branding to include both GRZ and USAID logos.</li> <li>• Branding to include warranty, expiry date, and warranty management should be handled by Provincial Medical Equipment Officer and District pharmacists.</li> <li>• Need for a joint inventory database for equipment.</li> </ul> <p><u>Capacity strengthening:</u></p> <ul style="list-style-type: none"> <li>• Train GRZ staff in good commodity management practices</li> <li>• Replacement of obsolete laboratory equipment</li> <li>• Train GRZ staff in pharmacovigilance</li> <li>• Orientation and disseminate of SOPs</li> <li>• Pharmacy mentorship program</li> </ul> <p><u>Transitional financing:</u></p> <ul style="list-style-type: none"> <li>• Continue to engage MOH while emphasizing the phased approach of the transition over time</li> <li>• To lobby for funding from EU, WHO and other stakeholders to implement &amp; roll out</li> </ul>	<ul style="list-style-type: none"> <li>• # Pharmacy departments refurbished and renovated by GRZ</li> <li>• Updated SOPs</li> <li>• # of trainings for HCWS in commodity management partially funded by GRZ</li> <li>• Availability of ART and Laboratory commodities in facilities.</li> <li>• # of districts with functional Pharmacy mentorship programs</li> </ul>
<p>IT TA Support and equipment for information systems</p>	<p><u>Inputs:</u> HR, Equipment, Finances, stationery, training manuals.</p> <p><u>Activities/tasks</u></p> <ul style="list-style-type: none"> <li>• Needs assessment in facilities to identify equipment needs</li> <li>• Develop &amp; implement plans based on identified gaps</li> <li>• Conduct IT support to health facilities</li> </ul>	<p><u>The institutions that will absorb activities:</u> MOH/MCDMCH (PCTOs, DHIOs), other stakeholders</p> <p><u>Procedures/guidelines/tools that will be changed:</u></p> <ul style="list-style-type: none"> <li>• IT policies and training guides/manuals for PCTO/DHIO</li> <li>• IT equipment purchases to comply with GRZ standards</li> </ul> <p><u>Capacity strengthening:</u></p>	<ul style="list-style-type: none"> <li>• Number of training plans developed.</li> <li>• Number of training manuals developed.</li> <li>• Number of trainings conducted/staff trained.</li> <li>• Number of IT assessments conducted</li> <li>• Number of plans developed for IT equipment and</li> </ul>

	<ul style="list-style-type: none"> <li>• Creation of provincial database to capture and manage all equipment at provincial level</li> <li>• Align IT equipment purchases with GRZ standards.</li> <li>• Conduct IT capacity development trainings in IT to 10 districts</li> <li>• IT assessments/planning for equipment and networking in supported districts</li> <li>• Roll out IT capacity building trainings to remaining 46 districts</li> <li>• Set up IT standards and policies.</li> </ul>	<ul style="list-style-type: none"> <li>• Training of PICTO/DHIO to enable them to take on IT Support roles. Training plan included in D-SERVE</li> <li>• Conduct Joint IT needs assessments and support visits PCTO and DHIO.</li> <li>• Procure IT equipment as determined by GRZ</li> </ul> <p><u>Transitional financing</u></p> <ul style="list-style-type: none"> <li>• Although GRZ will take over some of the key elements of the program, Donors will continue to finance this process.</li> <li>• Need to leverage resources from various donor projects</li> </ul>	<p>networking in supported facilities</p> <ul style="list-style-type: none"> <li>• Number of DCMOs implementing aspects of the GRZ IT standards and policies</li> <li>• Number of IT support visits by the PICTO/DHIO</li> </ul>
<p>Training, placing, and supporting community volunteers to support HIV/AIDS Services( CT, lay counsellors, PMTCT, Counsellors, and ART adherence support workers)</p>	<p><u>Inputs:</u> HR, Finances, CV training materials, equipment( bicycles, rain coats, gumboots)</p> <p><u>Activities/tasks</u></p> <ul style="list-style-type: none"> <li>• Refresher trainings in, HTC, PMTCT, eMTCT, MMC and ART counselling</li> <li>• Joint supervision of CVs with GRZ district &amp; facility staff.</li> <li>• Follow up on policy direction on CVs following setting up committee at MCDMCH.</li> <li>• Conduct supervision to CVs</li> <li>• Provide monthly allowances to CVs (\$30/month</li> </ul>	<p><u>The institutions that will absorb activities:</u></p> <ul style="list-style-type: none"> <li>• MCDMCH, Other stakeholders</li> </ul> <p><u>Capacity strengthening:</u></p> <ul style="list-style-type: none"> <li>• Support development &amp; formalization of community data collection, reporting, analysis &amp; use in routine HMIS, SmartCare</li> <li>• Joint supervisory activities to CVs with Districts/facility staff.</li> <li>• Refresher trainings for trainers of CVs</li> <li>• Replacement of bicycles &amp; other material logistics (raincoats, gumboots, stationery) to CVs</li> </ul> <p><u>Transitional financing:</u></p> <ul style="list-style-type: none"> <li>• In the interim, project to provide transitional result-based financing to GRZ &amp; gradually transition these cadres to other partners including USG.</li> </ul>	<ul style="list-style-type: none"> <li>• #Refresher courses for HCWs/Community volunteers</li> <li>• # of joint supervisory visits conducted</li> <li>• Availability of equipment &amp; key supplies for CVs' work.</li> <li>• Mechanism for supervising and managing volunteers finalized</li> <li>• strategy to absorb community volunteers into GRZ management and financing system developed</li> </ul>

			<ul style="list-style-type: none"> <li>• Community information management system developed</li> </ul>
Managing Data Entry Clerks	<p><u>Inputs:</u> HR, Finances, computers, internet facility, Filing cabinets</p> <p><u>Activities/tasks</u></p> <ul style="list-style-type: none"> <li>• Recruitment and deployment</li> <li>• Provision equipment (computers, internet, filing cabinets) &amp; stationery to DECs</li> <li>• Provide salaries/fringe benefits to DECs</li> <li>• Identification, selection and deployment of DECs</li> <li>• Conduct supervisory visits to DECs</li> <li>• Joint planning &amp; review meetings</li> <li>• Joint M &amp; E activities</li> <li>• Engage new partners to support work of DECs</li> </ul>	<p><u>The institutions that will absorb activities:</u> MCDMCH/MOH, other stakeholders</p> <p><u>Procedures/guidelines/tools that will be changed:</u></p> <ul style="list-style-type: none"> <li>• Harmonization of the ZPCTII B financing system with the Result Based Financing System by end of D-SERVE</li> <li>• Up grading of CBVs to Community Health Assistances through trainings-by end of D-SERVE</li> </ul> <p><u>Capacity strengthening:</u></p> <ul style="list-style-type: none"> <li>• Provide /service computers</li> <li>• Support to Internet services</li> <li>• Provide Refresher/Training courses to DECs</li> <li>• Joint Supervisory visits to DECs</li> <li>• Mentroship visits to DECs through PA Process</li> </ul> <p><u>Transitional financing:</u></p> <ul style="list-style-type: none"> <li>• GRZ must be engaged to determine the most appropriate mechanism to finance the transition.</li> <li>• IFMIS may be used to support direct district financing.</li> <li>• Engage other stakeholders to take up the support of DECs work.</li> </ul>	<ul style="list-style-type: none"> <li>• # of DECs on GRZ pay roll</li> <li>• # of trainings/refresher courses undertaken</li> <li>• Reports on mentorship visits &amp; actions taken</li> <li>• # of facilities with well functioning computers.</li> <li>• # facilities with continuous supplies of necessary logistics/supplies</li> <li>• # of facilities with adequate data storage</li> </ul>
Renovating health facilities	<p><u>Inputs:</u> HR, Finances</p> <p><u>Activities/tasks</u></p>	<p><u>The institutions that will absorb activities:</u> MCDMCH/MOH</p> <p><u>Procedures/guidelines/tools that will be changed:</u></p>	<ul style="list-style-type: none"> <li>• # of facility assessments jointly conducted by MOH/ZPCT IIB</li> <li>• # of works included in the infrastructure</li> </ul>

	<ul style="list-style-type: none"> <li>• Assessment of facilities to identify &amp; prioritize sites requiring refurbishments/renovations</li> <li>• Create Sketch drawings</li> <li>• Creation of BOQs, budgets &amp; implementation plans</li> <li>• Review and award contracts</li> <li>• Conduct inspections of works in collaboration with Ministry of Works (MOW)</li> </ul>	<ul style="list-style-type: none"> <li>• Use of Firm fixed price contracts for new construction with fixed scope.</li> <li>• Hasten the process for variation contracts for any additional costs arising from unforeseen extra works (under refurbishments).</li> <li>• Improve on confidentiality and follow government policy of non disclosure of tender evaluation outcomes before contract award</li> </ul> <p><u>Capacity strengthening:</u></p> <ul style="list-style-type: none"> <li>• Feasibility assessments and estimation of costs-PIO</li> <li>• Patient flow and infection control-PIO</li> <li>• Production of standard architectural drawings, and BOQs using SMM7-PIO</li> <li>• Donor rules and regulations-DCMO/PIO</li> <li>• Contract administration and inspections-EHTs/PIO</li> <li>• Supervising, monitoring, inspecting and certifying works</li> </ul> <p><u>Transitional financing</u></p> <ul style="list-style-type: none"> <li>• Funding position Provincial Infrastructure Officer which is not in GRZ structure</li> <li>• Lobby for the position of District Infrastructure Officer which also requires funding, but required</li> </ul>	<p>operational plans and budgets.</p> <ul style="list-style-type: none"> <li>• # of works tendered/executed jointly by MOH/D-SERVE</li> <li>• # of MOH staff oriented in donor rules and regulations.</li> <li>• # of refurbishments funded through GRZ</li> <li>• Proportion of GRZ funds committed to refurbishments</li> </ul>
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## Appendix B: Specifics on the transition plan for training service providers for HIV/AIDS service delivery

### Description of ZPCT program element

#### *Intended outcomes*

This programme element enhances the health care providers' ability to effectively deliver high quality HIV/AIDS services to clients through training. The quality of the training is monitored through the use of the pre and post test administered at each training held. In addition, the number of health workers trained is collected at every training and submitted to the training department. In every year, between 7 and 49 training sessions are held in each of the different HIV/AIDS service areas including ART, CT, MC and PMTCT.

#### *Outputs*

The project (ZPCTII) has trained:

- 2014 HCWS in Counseling and Testing: Basic C&T (577), Couple Counseling (355), Child counseling (290), Supervision counseling (232), Youth C&T (174), C&T refresher (386)
- 4192 HCWS in provision of PMTCT: Basic PMTCT (2433), PMTCT refresher (1759)
- 2697 HCWS in provision of ART: ART/OIs (1349); Pediatric ART (794); ART refresher (599)
- 470 HCWS trained in provision of male circumcision
- 963 individuals trained in provision of laboratory-related activities
- 277 in FP

#### *Processes*

1. **Planning:** Trainings are planned based on the projects five year targets, which are then broken down annually for the whole project and each province.
2. **Training needs assessment:** When ZPCT first starts working with a new facility it administers a training needs assessment to identify training needs. For old supported sites, training needs are identified on an ongoing basis by provincial technical officers when they make mentoring (TA) visits to facilities, which they communicate to the ZPCT training unit.
3. **Training plans:** District training plans and schedules are then developed with the District Community Health Office according to the project targets.
4. **Training of Health Care Workers:** Participants for the planned trainings are identified by the districts according to the needs identified by ZPCT staff and training slots allocated accordingly. ZPCT through Provincial Medical Office (PMO) sends letters to the districts indicating which facilities have been invited to the respective trainings. ZPCT provides trainers, the materials and finances required for the training.
5. **Post Training follow up:** The project conducts post-training follow up and technical assistance through ZPCT mentoring activities and pays trainers to follow up MC trainees.
6. **Quality in training:** Trainings have pre- and post-assessments to ensure quality
7. **Documentation:** A database is maintained of all participants.

### *Inputs*

The cost of each training ranges from USD 12,000 to USD 45,000 and includes costs for allowances for both GRZ certified trainers and participants, stationery, venue hire and transport costs for both organizers, trainers and participants. This is determined by the duration of the training and the number of participants and trainers required. The number of trainers required depends on the course, intensity of sessions and supervision required. The trainers will vary in number from 3 for didactic courses to 6 in practical competence based courses.

### *Related GRZ activities and initiatives*

The government plans for HIV/AIDS training activities in a bottom up approach. The District Community Medical Office (DCMO) consolidates facility plans which also includes short term training. Training needs are identified through Performance Assessment, Technical Supportive Supervision and Mentorship by the facilities and DCMOs who include them in their annual action plans usually without cost due to inadequate funds in the given IPFs. Trainings are held using experienced trainers at provincial level in order to have adequate number of participants and avoiding service delivery interruption. The success of the transition will depend in part on their ability to identify training needs and conduct training with experienced trainers.

The Ministry of Health headquarters also conducts a number of HIV/AIDS related trainings based on the needs identified from national activity reports and data. These also include ART, CT, MC and PMTCT. The similarity with ZPCT in trainings undertaken makes it easier to transition as they are government priorities. When funds are inadequate, MOH does resource mobilization and conducts some training with support from grants, CDC CoAg, Global funds, CHAI, and UNICEF. They also maintain updated database of trainees and trainers. In the transition period, they will be able to identify training needs, mobilise resources and continue training maybe at a lower level than the project.

MCDMCH does not have this data base of trainings yet. The District and Provincial Health Offices data bases are not up to date. There is a need to streamline participant invitations to have the correct people attend the training. There was need to streamline the planning periods between donors and GRZ and ensure only experienced trainers were used at all times.

### *Proposed transition strategy, steps/phases/stages, and timeframe*

The transition strategy for ZPCT supported trainings is to strengthen GRZ systems for identifying trainings needs and participants, establish rigorous procedures within GRZ for quality assurance and accountability, provide transitional funding for trainings (fixed-price contracts or fixed-obligation grants), and once a robust and accountable training management systems is institutionalized, negotiate for the gradual reduction in donor funding. Additionally, many training topics should be institutionalized into pre-service training, which may partially reduce the amount of in-service training needed. It may be some time before the GRZ has sufficient resources to pay for all HCW trainings. However, given that ZPCT II uses GRZ training manuals and GRZ certified trainers for all but a few very specialized trainings, GRZ is capable of organizing and managing HIV/AIDS related trainings if funding was made available to them, and rigorous accountability and quality assurance mechanisms were put in place. Some of these could be seen to happen by the end of the first year of D-SERVE while others will take time to even beyond the lifetime of D-SERVE.

**Ideas on specific elements of this strategy:**

As a first step, there would be a review of existing GRZ financial management, accountability procedures and enforcement for trainings, and identify any areas that may not be compliant with USG requirements and standards. In addition, a verification and quality assurance system would be designed in order to make it possible for GRZ to receive and effectively manage USG funding for trainings (in compliance with USG rules and regulations), and to ensure quality and effectiveness. This system would include institutional capacity strengthening in planning, financial management, documentation, and reporting practices possibly through embedded/seconded advisors provide support (their SOW would go beyond just trainings). Identified Provinces and Districts that successfully improve their systems, and can pass required pre-award assessment, sign output-based funding agreements such as a fixed price contract or fixed obligation grant for HCW HIV/AIDS trainings which could be expanded to additional training areas and districts. D-SERVE, working closely with GRZ, could then shift their focus onto the quality of GRZ certified trainers and the training curricula and materials.

**Possible metrics:**

- ✓ Number of districts that have systems in place to manage funding and trainings;
- ✓ Number of districts that are implementing trainings through grants/contracts;
- ✓ Value of USAID funding for training that has been transitioned to GRZ;
- ✓ Value of GRZ contributions to HIV/AIDS trainings
- ✓ Numbers of training participants.

## Specifics of the transition

*GRZ roles and responsibilities for tasks/activities*

<b>Tasks/ Activities</b>	<b>Responsible people</b>
Assess and identify training needs	DCMOs
Produce and monitor training plans	District and Provincial Planners
Identify training participants	DCMOs, PMOs
Maintain training database	MOH, MCDMCH, Information Officers working with HR at all levels (PMO, Hospital and DCMO)
Conduct refresher training for trainers	National level (MOH, MCDMCH)
Conduct refresher training for health care workers	National level and PMO
System of accountability for outputs	National level and PMO
Hold regular partner meetings and engage partners to support these meetings	PMOs
Coordinate and conduct training including adequate training documentation	National level and PMO
Verify quality of training	National level and PMO
Enforce financial regulations for training funds	PMOs
GRZ to take the lead on inclusion of in service training in to the pre service curricula.	National level

*Capacity strengthening needs*

Generally, there is need for provision of institutional capacity strengthening on planning, financial management, and quality assurance for trainings possibly through providing support through embedded/seconded advisors provide support (their SOW could go beyond just trainings). These would be ongoing for the duration of D-SERVE. A donor might still need to support most of these trainings even after D-SERVE.

There is need to strengthen provincial and district capacity and processes to:

- Systematically identify and track training needs based on performance assessments and mentoring
- Produce HR development/training plans (developed by district planner, DCMO, CCO, and NO, etc.)
- Coordinate/organize trainings
- Financial management (transportation allowance, etc.), and proper documentation and reporting on activities
- Verify that activities were implemented according to procedures

Other areas include strengthening the capacity of the Information Officers and HR Officers to maintain training databases which need to be standardized for donors and GRZ. There is also need to assess and identify how to support a common training system i.e. how to manage donors directly supporting PMOs with funds to manage training in the provinces using GRZ certified trainers and GRZ training materials to the donor standards if any different. In addition, there is need to regularize procedures for inviting participants empowering DCMOs who understand their own needs and staff to identify participants. These are short term and can be done by the end of the first year of D-SERVE.

#### *Procedural changes*

The job aids and the training materials need to quickly reflect any recent policy changes in each subject area. The procedure to update the training database needs to change to the donor model where the training registration form is used to enter data into the database immediately after the training by the HIOs in collaboration with the HR officers. GRZ needs to take the lead to assess current pre service curricula to see how to include some in-service training topics. Any areas in GRZ financial management and accountability procedures and enforcement for trainings that may not be compliant with USG requirements and standards might need to change after review.

#### *Buy-in*

The national level may be initially resistant to the ideas of taking on the financing of training due to resource constraints. In resolving this, there is need to harmonize donor and GRZ understanding of the entire transition process and timeline before GRZ finally takes over the entire financing for training. This includes emphasis on the entire process being done in collaboration with GRZ and that the initial steps in the transition would be those that might not require large or any financial resources such as harmonization of training databases. In addition, there would need to be additional resources from donors for some years till GRZ is finally able to take on this task. There could be resistance in updating training registers by GRZ staff who might perceive this to be a donor requirement when in fact it is a GRZ requirement. Trainers might be requested to complete the database for their particular training assignment as part of their scope of work. Changing the curriculum when the students have limited time in school and already have a lot to do in their course work, would probably be the biggest hurdle. One

model would be to take a couple of weeks while awaiting results after exams and before graduation to learn the in service training material if this can be supported by donors. These could be done by empowered local tutors certified by GRZ as trainers.

#### *Outputs and outcomes*

The number of staff trained would be sustained while donors still supported this activity then would be low initially when GRZ fully took this on and trained in accordance with the needs identified. This would eventually reduce if some of the in service training were put in the pre service curriculum.

#### *Inputs*

Training would be paid for in the transition period by donors while GRZ progressively took on more financial responsibilities for training. A number of models for financing training would be piloted and once successful would be scaled out to other provinces. One such model would be to use existing models where donor funds are given to GRZ to train while ensuring donor financial regulations and enforcement are followed including proper documentation. Training would be conducted using the GRZ training materials (manuals, job aids, presentation graphics, guidelines, data capturing tools etc.) and trainers currently involved in GRZ supported training. The other possible model would possibly be fixed-price contracts or fixed-obligation grants with each provincial and both national offices. Provinces and districts that are interested in receiving direct financing to implement trainings could be identified. For those districts that successfully improve their systems, and can pass required pre-award assessment, they would sign output-based funding agreements for HIV/AIDS trainings for HCWs (at least in some specific areas). As effectiveness and accountability are demonstrated, expand to additional training areas and districts.

#### *Quality assurance*

To maintain the quality of the training, GRZ would need to continue with the pre and post-test which are part of the standard GRZ approved training. In addition, continued practice of using experienced GRZ trainers with regular refresher trainings held at national level (which donor could initially support) for them would ensure more quality knowledge transfer with more updated and correct knowledge shared with participants.

## Appendix C: Specifics on the transition plan for providing supportive clinical mentoring and supervision in HIV/AIDS technical areas

### Description of ZPCT program element

#### *Intended outcomes*

Mentorship and supervision are meant to improve the quality and effectiveness of HIV/AIDS services. In addition, these activities strengthen initiation of previously unavailable services in health facilities. There has been an increase in adherence to HIV service standards and patients correctly initiated on ART based on certain eligibility. This has contributed to an overall increase in the cumulative number of clients on treatment and clients accessing these services. Mentorship and supervision are monitored through routine checks of documentation in patient files and facility HIV service registers and through data generated through routine M&E service statistics.

#### *Outputs*

Clinical mentorship and supportive supervision are conducted on a regular basis. Two to four (2 – 4) visits per quarter for PMTCT and clinical care/ART are jointly conducted with GRZ in the ZPCT supported facilities. This varies from province to province. In a quarter, an average of four (4) visits are conducted without GRZ counterparts. Visits for MC are conducted once or twice per quarter. Visits vary depending on the stage in the support; mature facilities require less visits (about 1-2 per quarter) while new facilities receive 1-2 visits per month.

#### *Processes*

1. **Mentorship and TSS visits:** ZPCT II technical officers based in ZPCT provincial offices make 1-3 clinical mentoring and supportive supervision visits per month and/or per quarter to support HCWs at all 450 ZPCT II supported facilities. This mentoring covers PMTCT, clinical care/ART, and MC including the laboratory, pharmacy, and M&E areas. The number of visits to a facility per quarter for each programme/service area is dependent on how recently the facility started providing the service, major changes in protocols in the technical strategy or the extent of staff turnover in the facility.
2. **Planning:** ZPCT technical officers plan their visits quarterly using a mentoring work plan template and a travel planning template, which are reviewed by managers and senior technical staff.
3. **Prioritisation:** The needs are always greater than the budget, so the team prioritizes using performance data and previous quarterly mentoring reports.
4. **Cost effectiveness:** Travel costs are saved by visiting facilities on the same route in one visit.
5. **Post training follow-up:** During these visits, ZPCT staff provide follow-up on any trainings provided.
6. **Service quality checks:** Project staff use a TA checklist to comprehensively review service quality and performance and check registers to verify service data;
7. **Support needs identification:** Any support needs (i.e., equipment, supplies, training, job aids)
8. **Dissemination:** ZPCT provincial staff disseminate national guidelines and protocols.
9. **Joint visits with GRZ:** These supervision visits are sometimes done jointly with GRZ (district or province based) technical counterparts.
10. **Documentation:** ZPCT mentors document needs, which are followed-up on the next visit.

11. **Communication:** identified needs in the facilities are communicated to the relevant Technical Officer at HQ to address. For instance, training needs are communicated to the ZPCT II training unit either to include the HCWs in planned trainings or to schedule a training in the following year's training plan. Lab equipment needs are communicated to the ZPCT II Laboratory unit.
12. **Clinical meetings:** ZPCT provincial technical officers (the mentors) will also attend HIV/AIDS related clinical meetings at hospital and district level to contribute to the discussions and learning as well as present data and case studies.
13. **Data Review meetings:** Similarly, ZPCT provincial technical officers attend quarterly district data review meetings organized by the DCMOs to provide technical input, present data and provide analytical feedback to presentations on facility performance in HIV/AIDS services, arising from project staff experience mentoring in the sites.
14. **Model sites:** ZPCT II set up model sites (well performing ZPCT supported sites) as a mentorship approach which were evaluated and showed that HCWs were more open to being mentored by other HCWs, and learnt better from demonstrations of best practices. Trained mentors at the model sites were given targets for maintaining service standards in surrounding facilities that sent HCWs to the model site to learn through demonstration on how services should be managed and delivered. Future plans for these model sites include enhancing the depth of the topics covered to more advanced topics such as 2nd line treatment failure.

#### *Inputs*

The project currently employs 3-4 full time technical officers covering each technical area namely PMTCT, clinical care and one officer for MC, in each province. On average, between USD 24,000 and USD 40,000 is used on staff allowances in each province per quarter to conduct mentorship and supervision visits. In addition to this, fuel costs amount to between K80, 000 and K135, 000 per quarter per province. Several tools are used to perform this activity. They include: ZPCT II TA checklists and mentorship planning and reporting tools, Job aids, various national guidelines and protocols.

#### *Related GRZ activities and initiatives*

GRZ has structures in place to coordinate and conduct quality mentorship. These are the Clinical Care Teams (CCTs) at both Provincial and District level drawing membership from experts in the various clinical areas. Mentorship needs are identified by GRZ through Performance Assessments and data review meetings. National mentorship tools are used during mentorship visits which are followed by Technical Supportive Supervision visits. This is done sporadically due to challenges with inadequate resources in terms of vehicles, finances and human resources. However, GRZ has prioritized this activity even in the yellow book where more funds have been allocated to mentorship than to Performance Assessments which was sometimes seen as a fault-finding activity without tangible follow up corrective action and/or technical support. DCMOs have some personnel to conduct mentorships but need more mentors and technical competences i.e. the right mix of competences and cadres. DCMOs should take lead in coordinating and facilitating integrated meetings with HC staff including data review meetings.

#### *Proposed transition strategy, steps/phases/stages, and timeframe*

To transition ZPCT mentoring activities, the general strategy would be to help strengthen the GRZ clinical mentoring system and then to integrate ZPCT II mentoring tools for PMTCT, clinical care/ART, and MC and their respective mentorship tools into GRZ system, perhaps using Fixed Price Contracts as a transitional

financing arrangement. This could be pursued initially with one province, and once the model is refined and proven, expanded to other provinces. Additionally, the project could continue to develop a cost effective model site approach as a potential enhancement to the GRZ clinical mentoring system.

**Ideas on specific elements of this strategy:**

The main strategy is to strengthen HIV/AIDS mentoring and supervision component of GRZ clinical mentoring teams system. This might include:

- Support GRZ to integrate ZPCT II mentorship tools (for supervision/mentoring for PMTCT, clinical care/ART, and MC) into the GRZ clinical mentoring tools. Currently GRZ does not have clinical mentoring tools for ART as part of the national clinical mentorship package.
- Support GRZ to use ZPCT II supervision management tools: quarterly plan template, quarterly travel plan template, quarterly report template (consolidating activities and findings across individual supervision reports), and procedures for managers reviewing and approving these plans. Though GRZ has defined the general process, it may lack these types of specific planning and management tools.
- Design enforceable requirements for completing planning, implementing supervision/mentoring, and completing reports (need strong system for incentives, and oversight procedures which the project could enforce if/while we are funding but which become institutional norms that remain after transitioning to government financing).
- To ensure that the people assigned to do mentoring have sufficient expertise in the technical area, work with provinces to establish technical certifications for clinical mentors in PMTCT, clinical care/ART, and MC, in addition to their general mentoring certification. Being a certified trainer in a technical area would automatically qualify a person to have mentoring certification in that area. Others that have expertise but are not certified trainers would need to be assessed before achieving certification.
- Continue to do joint mentoring with technical counterparts in the districts and provinces.
- Work with technical counterparts in districts and provinces to achieve the general mentoring certification as well as certifications in the technical areas that they would mentor in.
- Strengthening data use in districts and provinces (to use data simply and effectively), including attendance of GRZ clinical mentors, to effectively use findings from supervision/clinical mentoring (explain the “why” behind the performance numbers).
- Define clear performance expectations for clinical mentoring/supervision for PMTCT, clinical care/ART, and MC. Work with districts and provinces to plan for LOE and budget for the activities.
- Provide funding (e.g. fixed price contract or fixed obligation grant), perhaps as matching funding, to roll-out this model in a limited number of districts, funding GRZ clinical mentoring for PMTCT, clinical care/ART, and MC (perhaps focused in the mature sites, while D-SERVE focuses on the new sites).  
Work out the current concerns with model sites: No GRZ guidelines and tools currently exist. The current model of this mentorship approach is not cost effective but well appreciated by the mentees.
- Scale-up to the other districts and provinces
- Once the model has been fully institutionalized and stabilized, USG and GRZ negotiate a timeline to gradually reduce donor financing.
- Integrate model sites approach into the government clinical mentoring system
- Continue to develop and test the model site approach, working in concert with the GRZ supervisors/clinical mentors
- If it works well, document effectiveness and cost effectiveness of this model, and how it can complement/reinforce/add value to the current GRZ model for clinical mentoring teams.

- Use this evidence to convince relevant policy makers and managers to integrate this into the GRZ clinical mentoring system.
- Help develop official technical guidelines, budgeting guidelines, tools, etc. for model sites
- Provide TA for establishing model sites within each district

### Specifics of the transition

#### *GRZ roles and responsibilities for tasks/activities*

<b>Tasks</b>	<b>Responsible person/ institution</b>
Make monthly supervision visits for PMTCT	PMTCT mentors from CCTs
Make monthly supervision visits for clinical care/ART	Clinicians/ ART mentors from CCTs
Make monthly supervision visits for MC	Surgeons/ Trainers in MC from CCTs/Hospitals
Coordinate/Facilitate clinical meetings	Clinical Care: Hospital (HCC), District (CCO), PMO (CCS)
Distribute job aids, guidelines, and protocols	PMO: Senior Health Education Officer, DCMO: Environmental Health Officer
Follow-up on action items from previous supervision visit	PMO: CCS, DCMO: Relevant Programme Officer (CCO, NO etc.)
Follow-up on learning in training	PMO: CCS, DCMO: Relevant Programme Officer (CCO, NO etc.)
Communicate identified training needs to training program	Mentors through their report to CCTs onwards to Relevant Programme Officer at PMO.
Communicate identified equipment needs to equipment managers	Mentors through their report to CCTs onwards to Relevant Programme Officer at PMO.
Providing technical expertise in clinical meetings	Subject experts at PMO, Hospital and DCMO level
Providing technical expertise at district data review meetings	DCMO leads and works with CCO, NO and DHIO
Managing/coordinating/overseeing model sites	Clinical Care Specialist, Head of Clinical Care
Coordinate joint planning with partners using a bottom up process	PMOs
Identify mentorship needs	PMOs and DMOs
Manage the mentorship programme including funds	PMOs and DMOs
MOUs must be recipient driven	PMOs and DMOs

#### *Capacity strengthening needs*

Joint planning between GRZ and donors for donor supported work will need to be strengthened through an initial process of enhancing communication through regular monthly or quarterly planning and update meetings. This is where the donors will meet with the PMO and DCMO staff to discuss activities and plan for the subsequent quarter. These could be between Programme Officers to streamline activities and get donors to buy in to the GRZ plans. These can begin immediately to establish a feasible process that can be rolled out to other provinces from the initial pilot province? This would also mean that ZPCT would

review its process for generating recipient agreements to include this aspect of collaboration and make a foundation for subsequent work between GRZ and any other donor.

Another area to strengthen is the capacity of GRZ to manage resources (human resources, finances and transport) required for mentorship. This could possibly be done through initial joint visits and planning with ZPCT staff in order to build capacity to manage this activity and these resources. HIV/AIDS competences in Clinical Care Teams at PMO and DCMO level would be strengthened to manage mentorship and make joint visits more regular. Mentorship visits could use this strategy as a vehicle to strengthen and integrate mentorship with other routine visits. These activities could be started in selected districts and provinces in the bridge to perfect the model found to be successful before scaling up to the remaining districts. The main objective is to enhance and work within the GRZ mentorship system.

#### *Procedural changes*

For mentorship to be successfully transitioned to GRZ, there would be need to strengthen GRZ mentorship structures, use of GRZ mentorship tools including reporting tools to document HIV/AIDS related mentorship activities for accountability. This would involve reviewing and updating i.e. inclusion of any other relevant HIV/AIDS indicators, in the HIV component of the relevant existing GRZ tools such as PA tools that inform and guide mentorship in HIV/AIDS service areas. In addition, the project would lobby with GRZ and other stakeholders through the TWG on adoption of HIV/AIDS mentorship tools as part of the GRZ mentorship programme tools to support more harmonized mentorship in the area of HIV/AIDS. Tools (data collection, mentorship and reporting tools) reflecting the new policy decisions need to be developed and distributed as soon as possible to enhance service delivery in line with new standards and guidelines. This could be done through the relevant TWG at MOH with donors initially supporting the printing for these changes.

#### *Buy-in*

Resistance would be minimal in this area as it is something that the government is supporting already. However, there could be some resistance to how quickly the tools need to change to reflect the new guidelines. In addition there could be some resistance when it comes to adding more indicators to the already bulky PA tool in the current thinking of reducing its size. GRZ needs to lead this process in line with their policy and strategic direction and get stakeholder consensus. The tool would be reviewed for any deficiencies and specific areas which need inclusion would be identified which would be the basis for discussions with the two ministries and other partners. The mentorship reporting tools were seen as bulky and there could be some resistance to their use particularly when seen as a donor driven process. This could be resolved by emphasizing that mentorship is a GRZ programme and reporting is a big component of this programme with important spillover effects such as informing training or equipment maintenance needs.

#### *Outputs and outcomes*

With decentralized mentorship i.e. provinces and districts conducting more mentorship using additional donor support, there is bound to be sustained mentorship which might not initially be at the ZPCT level but this will increase with more stable/regular programming, planning and funding. Regular scheduled mentorship would initially sustain and eventually increase the documentation of these mentorship visits and ultimately increase the quality of services.

### *Inputs*

Initially, mentorship can be paid for by leveraging available resources between donors and the GRZ. This could be facilitated by having a joint mentorship planning process based on available resources. The mentors from both donors and GRZ could work together and transport resources could be shared to achieve mutual goals. This process could begin in the first year of D-SERVE. GRZ resources could incrementally be used to support mentorship during the D-SERVE and any other follow on project supporting this activity.

### *Quality assurance*

The use of GRZ mentorship tools will enhance the maintenance of the quality of mentorship and supervision. Quality will be enhanced through building the capacity of the CCTs to enable them to conduct quality mentorship sessions which inform capacity building needs and equipment maintenance needs. Regular refresher trainings held for mentors will be an added effort needed to maintain the quality of mentorship.

## Appendix D: Specifics on the transition plan for using tools for measuring and monitoring the quality of HIV/AIDS services (QA/QI tools)

### Description of ZPCT program element

#### *Intended outcomes*

This programme element is meant to improve the quality of HIV service delivery in ZPCT II supported health facilities through assessing and enforcing the national standards for HIV/AIDS services. With sustained high quality HIV services, there would be reduced technical assistance by ZPCT II i.e. district graduation. QA/QI is monitored routinely through QA/QI tools which are administered by the provincial ZPCT technical staff on a monthly or quarterly basis in each facility depending on the frequency of mentorship and TSS visits. These reports are submitted to the data management team that enter them in a data base and analyse them for common weaknesses which are addressed in the data review meeting or followed up with mentorship or TSS visits. QA/QI has been strengthened in the supported facilities through formation of QI committees and initiation of QI projects.

#### *Outputs*

- QA/QI tools have been updated when new guidelines are released to reflect the new standards and guidelines health workers are expected to adhere to.
- 200 facility staff are trained in quality improvement and quality assurance per year
- 2,050 individual QA/QI forms entered into the system in 450HFs per quarter
- 1,000 quality improvement action plans developed 450HFs per quarter
- 20 routine summary QA/QI reports produced per year
- Nine facility based quality improvement projects completed in seven districts

#### *Processes*

1. **Quality assessments:** QA/QI deals with assessing and enforcing the national quality standards in HIV Services.
2. **Development of QA/QI tools:** The HIV/AIDS service QA/QI tools are derived from the national SOPs and guidelines. QA/QI tools assesses technical competency, human resources, information systems and space in Clinical care / ART, Counseling & testing / Prevention of mother –to-child transmission, laboratory services, pharmacy services and monitoring & evaluation. The tools are updated as soon as there are changes in the guidelines e.g. the consolidated HIV guidelines. There is no set procedure to update the QA/QI tools but the technical team in the Lusaka project office often does this.
3. **Data collection and analysis:** Collection of QA/QI data is integrated with routine mentorship visits. These tools are administered by provincial ZPCT technical officers on the team jointly with MOH staff. Quality improvement action plans are developed at the health facility based on the identified gaps and agreed actions with specific persons and time frame for implementation. Administration of QA/QI tools is done quarterly with immediate feedback to health facilities. Further data analysis is conducted at the ZPCT provincial office where common weaknesses from QA/QI tools are identified, discussed and addressed during data review meeting where all ZPCT staff are present. The weaknesses unique to a facility are addressed through mentorship or TSS.

The identified gaps and action plans are shared quarterly with district, provincial health offices and ZPCT Lusaka office through summary provincial quarterly QA/QI reports.

4. **QI Training:** ZPCT supports QA and QI training using GRZ trainers and MOH training manuals for Health facility staff in the ZPCT supported sites.
5. **QI facility support:** QI committees are formed in each supported site and ZPCT supports their monthly clinical meetings. ZPCT technical officers work with health centre staff to identify HIV/AIDS service related quality problems that they address through the national QI strategy of choice, the Performance Improvement Approach (PIA) Framework by development of QI projects and action plans.
6. **District graduation:** Districts sustaining high quality of HIV and support services are graduated i.e. they receive less technical assistance by ZPCT and the DCMO takes over. So far, 42 districts have been graduated with the standards sustained in all 42 districts.

### *Inputs*

QA/QI has been integrated into the routine clinical mentorship visits thereby having the costs embedded in the clinical mentorship TSS costs of between USD 24,000 TO USD 40,000 per quarter per province. Other costs include staff time for data collection, analysis, reporting and updating QA/QI tools. Equipment, stationery for data collection tools, job aids and reports are also included. Three to four provincial technical officers administer the QA/QI tools at each visit which come to an average of 6 per quarter per facility. Tools are printed in bulk from the head office and distributed to all provinces. These tools assess the services according to set standards and are compiled and analyzed using CSpro and EPinfo software, which is used to print reports using a standard reporting template.

### *Related GRZ activities and initiatives*

GRZ has developed and disseminated QI national guidelines for HCWs which recommends the use of the Performance Improvement Approach (PIA) Framework as the national QI strategy of choice. They have also conducted QI trainings for Provincial, District & facility staff. GRZ conducts Performance Assessment (PA) biannually and clinical mentorship which are QI strategies. QA/QI tools are used to identify mentorship needs and to ensure the quality of service provided is of high standard. QI reports are used to guide review meetings and identify service gaps for follow up. GRZ through its national QI programme, track national QI indicators through the routinely collected Health Management Information System. Buying into an already existing GRZ system makes the transition easy and guides the transition strategy.

### *Proposed transition strategy, steps/phases/stages, and timeframe*

To transition ZPCT support for QA/QI, the general strategy would be to align it with the national QI programme structures and systems as well as strengthen the linkages between the QA and mentorship program which all districts would be implementing. This could be done by formation and strengthening support to local health facility and District QI committees. ZPCT could support implementation of this strategy in one or two districts where one of the deliverables in the recipient agreement could be having functional QI committees with terms of references including use of the QA/QI tools, having regular meetings to discuss the QA/QI data and implementation of QI projects. This can then be refined and scaled up to include other districts. Administration of QA/QI tools can be integrated into the mentorship programme to operationalize it given that mentorship is a subset of QI.

**Ideas on specific elements of this strategy:**

Support GRZ to integrate ZPCT II QA/QI tools (for supervision & mentoring for PMTCT, clinical care/ART, laboratory, pharmacy, monitoring & evaluation and MC) into their clinical mentoring tools.

To be able to do this effectively, ZPCT will need to align and integrate its QA/QI work with the national QI program structures and systems. This would include working with GRZ in the following steps:

1. Identify which districts and facilities have functional QI committees
2. Strengthen selected QI committees by supporting meetings,
3. Training in the use of the QA/QI tools for DCMOs to monitor QI activities and health facilities to conduct self-assessments
4. Continue support for training in QI using national QI training package and GRZ provincial trainers
5. Plan for TSS and mentorship in QI in ZPCT supported health facilities and agree on criteria for graduated facilities/districts as well as what support will be provided for these.
6. Include having QI meeting minutes and self-assessment on file as part of the “deliverables” in the recipient agreement

### Specifics of the transition

#### *GRZ roles and responsibilities for tasks/activities*

GRZ national level representatives from both ministries would lead the integration process of QA/QI tools as recommended standards of care into the mentorship tool and in the Performance Assessment tool. This would be done by reviewing and comparing the current HIV services assessments conducted using mentorship and Performance Assessment tools with the QA/QI tools, with a view to merge them into one comprehensive tool.

The Clinical Care specialist (PMO), Head Clinical Care (Hospital level), Clinical Care Officer (DCMO) would coordinate QI activities in their areas of influence and working with their respective Information Officers would be responsible for collecting, analyzing and disseminating QA/QI data.

Clinical Care Officers will ensure monthly or quarterly integrated review meetings are held where QA/QI activities will be discussed as part of the agenda items.

Provincial Medical Offices & District Community Medical Offices will strengthen the use of Performance Assessment tools. They will ensure that the PA tools are consistently administrated in all districts and in all facilities within the district.

#### *Capacity strengthening needs*

To strengthen GRZ capacity, more health care workers need to be trained in Quality Improvement for them to have the capacity to identify quality gaps in the HIV service provision and develop quality improvement action plans to address the identified gaps to improve the quality of HIV services. GRZ QA/QI capacity will be strengthened through conducting of new and refresher trainings in QI. To cement the trainings, QI trainers will mentor the trained QI practitioners through joint visits to health facilities and through regular TSS visits. Monthly or quarterly QI meetings at health facility level, district and provincial levels will be facilitated and supported. This could be done through allocation of limited funds to hold these meetings at the different levels in the recipient agreements. In addition, program planning for GRZ

and ZPCT should be synchronized to enable joint planning and joint technical supervision support to DMCOs and health facilities.

#### *Procedural changes*

To make it possible for GRZ to implement the QAQI program element, the performance assessment tool and mentorship tools' HIV component will need to be strengthened to comprehensively capture all HIV quality dimensions. Health center use of the QAQI tool to do self-assessment of their HIV service provision needs to be integrated into their routine health service delivery and monitoring systems.

#### *Buy-in*

Additional documentation requirements might be seen as a problem and resented by HCWs who might be overworked but if this is shown as a GRZ QI Program requirement and not a donor requirement, such resistance might be overcome. QI project implementation needs regular meetings which the staff feel they are unable to have regularly due to large number of required meetings, short staffing and high patient loads. Therefore, building the facility capacity to have integrated meetings routinely where QA/QI is a permanent agenda item would make this possible. Supervision requires intense visits to the facilities which might be initially unaffordable for the districts particularly when they have a number of other competing priorities. This could be overcome by strengthening integration of visits as well as initially supplementing GRZ funds with donor funds.

#### *Outputs and outcomes*

With more intensive support and strengthening of QI activities, the comparatively lower initial levels of support by GRZ will increase and be sustained. With more strengthened decentralized QAQI activities and additional support, there is bound to be an increase in QI activities and project implementation as GRZ takes on more responsibility for QI programming, planning and funding. This will result in improvements in documentation of the QI activities and thus the quality of services is also expected to improve.

#### *Inputs*

Initially, funds for QAQI will be included in the recipient agreements for the PMOs, DCMOs & health facilities. There will be need to harmonize funding for this activity in order to share budgets and resources. This will require a defined process which can be approved by our GRZ counterparts, piloted and rolled out to other districts once proven successful. It could be part of the activities funded under FOGs with stringent regulations for the use of the finances tied to feasible outcomes/outputs. QI teams would take the lead conducting QI activities in their stations which would not need so much funds based on QI principles of resolving local problem within available resources. To make QI more successful would require integration in routine service delivery rather than a standalone program. This will begin to happen in the lifetime of D-SERVE. With time towards the ends of D-SERVE, the GRZ component of financing QI activities would increase particularly that the QI mentors are mostly GRZ and there are QI teams in most GRZ institutions which will be strengthened. Furthermore, incorporation of QI in the annual GRZ action plans will ensure some funds are committed and dedicated to this activity.

### *Quality assurance*

The incorporation of ZPCT QAQI tools into the GRZ QI system for identification and assessment of quality issues in line with GRZ standards and guidelines will enhance the maintenance of the quality of QAQI activities. Further, building the capacity of the QI teams to enable them to provide quality oversight and management (supportive supervision) of the QI program will inform capacity building needs particularly in problem identification and implementation of QI projects.

## Appendix E: Specifics on the transition plan for strengthening laboratories for HIV/AIDS related testing

Description of ZPCT program element

### *Intended outcomes*

This program element is meant to ensure effective laboratory services to support HIV/AIDS service delivery, including identifying HIV+ clients, timely interventions (such as initiation of clients on ART), and proper management of ART clients.

In order to effectively monitor the performance of laboratories, the project implements a performance monitoring plan which includes performance indicators for HIV/AIDS technical strategies supported by the project. The PMP is a critical management tool to plan and manage the collection, analysis, and reporting of performance data in the government facilities supported by the project. Under lab the key indicators are:

- Number of PEPFAR-supported testing facilities with capacity to perform clinical laboratory tests
- Individuals trained in the provision of laboratory-related activities

Other indicators include: # of CD4 count/% tests performed, # of abnormal creatinine results, # of creatinine tests performed, # of abnormal liver function results, # number of liver function tests performed, # of syphilis tests performed, # of TB tests performed, # of CD4 tests referred.

### *Outputs*

There are 131 laboratories with capacity to perform CD4/lymphocyte tests. These laboratories are responsible for supporting the PMTCT and ART program as they provide diagnostic and monitoring tests. The Project has successfully supported the Early Infant Diagnosis program through establishment of the PCR laboratory at ADCH, which now has added capability to provide viral load testing, apart from EID. The laboratory has all the equipment and training needed to do HIV Early Infant Diagnosis (EID) for 660 facilities. Currently, ADCH is processing 20,000-25,000 samples for HIV EID every year (~400 per week). EID capability at ACDH contributes to the 60% of national EID testing done and facilitates timely interventions for Pediatric ART.

The 131 laboratories have been supplied with the following major (high value) laboratory equipment worth \$2,237,960: ABX Micros (66), Facs Count (106), Facs Calibur (1), PentraC 200 (14), Sysmex Poch100i (50), and CAP/CTM (1).

ZPCT II supplied 167 laboratories with the following minor (low value) equipment worth \$717,000: Haemocue POC (318); Bench Centrifuges (31); Shakers (23); Microscopes (15); Haematocrit Centrifuges (8); Micropipettes (273); Roller Mixers (28); Water Distillers (9); Vortex Mixers (26); Thermal Mixer (1); Thermal Block (1); Nutating Mixer (1); Microplate Reader (1); Microplate Washer (1); PIMA POC (60); Autoclaves (31); Lab Stools (7); Uninterrupted Power Supply-UPS (5); Surge Protectors (30); and Refrigerators.

The project also supports a CD4 sample referral systems that allows around 65% of facilities to be able to refer CD4 test samples to one of the 131 laboratories with CD4 testing capabilities. This system has enabled an average of 38,000 CD4 tests being done per quarter.

The project has also assisted health facilities to receive MOH approved External Quality Assessment proficiency panels in a timely manner thus allowing for timely responses to assessing agencies.

The project holds three trainings per quarter for lab staff on laboratory equipment use and maintenance. A total of 963 were trained over the life of ZPCT II, and 60 will be trained in ZPCT IIB.

### *Processes*

1. **Needs assessment and prioritization:** To procure major (high value) and minor (low value) laboratory equipment, the project first conducts a facility needs assessment to identify facilities that require laboratory equipment. Needs are greater than the budget, so priority is determined based on whether a facility is an ART accredited center, catchment populations served, numbers of clients eligible for ART, and numbers of clients on treatment.
2. **Procurement:** The project then plans and implements the procurements following project and USAID procedures. The project only procures major equipment that are included in the MoH approved equipment list.
3. **Setting up PCR laboratory:** Working closely with MOH in 2007, ZPCT II established the PCR laboratory at ADCH (Ndola) resulting in the lab having Early Infant Diagnosis capacity to service 660 facilities in the northern part of Zambia. This included procuring the necessary equipment, training lab staff, arranging a contract for courier services for transporting DBS samples and results, putting in place incentives for extra shifts, and placing two full time staff and two data entry clerks. The project continues to support EID by paying for many of the costs to run the system, including extra shifts, courier services, maintenance and repair, ad hoc reagent procurements, and salaries for the DEC's and two full time ZPCT staff.
4. **Equipment maintenance and repair:** For equipment maintenance the project depends on vendors fulfilling the agreed service obligation based on the 10% procurement price mark-up designated for servicing. Repairs have not been comprehensively addressed with government primarily depending on partners to cover repair costs. Each year, the project examines equipment break-down trends to plan the project maintenance and repair budget for the following year.
5. **Training of laboratory staff:** The project works with vendors of the specified equipment to train laboratory staff on the use and maintenance of major pieces of laboratory equipment. Trainings are scheduled regularly to capture those who have yet to be trained (new staff or newly placed equipment) and as needed to update people on equipment upgrades or changes in protocols. The vendors develop the curricula and provide the trainers. The project coordinates and hosts the event, identifies participants, and pays allowances.

6. **External quality assessments (EQA) for laboratory tests:** The project works with the Ministry of Health to support external quality assessments (EQA) for laboratory tests. When a testing center is enrolled in EQA, the project will pick-up samples from the national reference laboratory or its equivalent and during routine TA visits mail/transport the samples to enrolled MOH facilities. The project then follows up the performance of the enrolled facilities and assists with structured corrective actions if needed.
7. **Refurbishments/renovations for laboratories:** On an annual basis, the project identifies facilities needing improved or modified space. This is done collaboratively between ZPCT Provincial Laboratory Officers, Provincial Infrastructure Officers and the appropriate MoH facility authorities, DCMO and PMO. The project then prioritizes needs, and schedules the works.
8. **CD4 Sample Referral System (SRS):** Working with the MOH and MCDMCH, the project helped to establish and is supporting implementation of a CD4 Sample Referral System (SRS) covering 270 health facilities. Initially, the project identified and mapped ART and PMTCT sites without labs, designed a network of motorcycle couriers to routinely collect samples from these facilities and deliver them to the labs with CD4 testing capabilities, procured 119 motorbikes, identified and trained riders, developed the pick-up schedules, pays for the fuel and allowances for the riders, and also pays for the maintenance and replacement of motorbikes. Results are sent via the courier system and finally to specific sites via motorbikes or for sites that are networked and have an sms printer, these are sent via sms. The project is working very closely with MoH and UNICEF to have additional sites networked on the sms system.

#### *Inputs*

- Procurement of high value equipment in 131 laboratories cost the project \$2,237,960 over five years
- Procurement of low value lab equipment in 167 laboratories cost the project \$717,000 over five years
- Maintenance of laboratory equipment cost the project K750,000/year
- Ndola PCR lab – staff salaries, DEC's and equipment maintenance costs the project K558,000 /year
- Ndola PCR lab-procurement of equipment cost the project \$279,985 over five years
- Renovations in 143 laboratories cost the project \$1,032,000 over five years
- Training in equipment use and maintenance cost the project \$145,000 over five years
- Commodity management training cost the project \$145,000 over five years
- Sample referral system for CD4 (procurement of motorcycles and operational costs) cost the project \$890,000 over five years

#### ***Staffing levels***

There are different levels of healthcare laboratories with different requirements for establishments. The tertiary institutions seem to be adequately staffed while district hospitals are not adequately staffed by laboratory professionals. Some health facilities have Environmental Health Technicians who run laboratories.

#### ***Tools, materials, and equipment used to perform work in the program element***

The project uses MOH approved Standard Operating Procedures (SOP) that are designed by level of care, quality and safety manuals, WHO approved accreditation checklist. For policy guidance, the project uses ART and PMTCT guidelines, the National Medical Laboratory Policy. There are also instrument specific

guidelines that are used, e.g. the Point of Care CD4 PIMA analyzer, the National Accreditation guidelines as formulated by Health Professions Council of Zambia.

#### Related GRZ activities and initiatives

- GRZ procures high throughput platforms (laboratory analyzers) when budget allows for all levels of health care.
- GRZ facilitates some equipment use and maintenance training (at installation)
- GRZ takes a lead in organizing, coordinating and hosting the national quantification exercise
- GRZ procures motorbikes for districts and supports operational costs
- GRZ facilitates for equipment maintenance service contracts with international vendors
- GRZ facilitates for construction of new laboratories through construction of new health facilities
- GRZ facilitated the National medical laboratory policy (collaboratively with Health Professional Council of Zambia, and Biomedical Society of Zambia)
- GRZ recruits and places laboratory staff in tertiary facilities, all district hospitals and mostly urban clinics. Some staff at Churches Health Association of Zambia (CHAZ) supported sites are also recruited and placed by government.

Currently, there is the National Laboratory Strategic Plan (2012-2016) which is being funded by government and other stake holders. However, even though government is playing a significant role in funding and implementing laboratory services in support of HIV/AIDS service delivery, greater levels of funding would increase GRZ's capacity to absorb project supported activities.

#### Proposed transition strategy, steps/phases/stages, and timeframe

- Consultative meeting with Chief Equipment Application Specialist (MOH, Lusaka ) to validate transition strategies discussed at Chaminuka meeting by April 2015
- Consultative meetings with Provincial Laboratory Scientist, District Laboratory Scientists (where they exist) and Provincial Medical Equipment Officer to map out preliminary strategies by April 2015.
- Quarterly joint visits with the Provincial Laboratory Scientist, District Laboratory Scientists (where they exist) and Provincial Medical Equipment Officer to provide technical assistance, monitor equipment functionality, and determine repair and servicing needs.
- Engage PMO on the potential to use of Provincial Medical Office motor vehicle service center for repair and servicing of project motorcycles and air conditioners that are beyond warranty, by April 2015
- Engage MOH Chief Equipment Application Specialist to discuss training plan for District Biomedical Equipment Engineers what role the project can play in implementing the plan by May 2015
- Explore viability of extending commodity management skills and knowledge to other health professionals to maximize technical assistance impact during respective supervisory visits, by April 2015.
- Engage MCDMCH to explore possibility of the ministry assuming responsibility for costs associated to DBS EMS service to ADCH PCR Laboratory in Ndola by April 2015.
- Creation of provincial database to capture and manage all equipment at provincial level by August 2015.

- Oversight of commodity status at district level fully managed by District Pharmacists by 2017 (no position for District Laboratory Scientist in GRZ establishment)
- Pharmacy mentorship programs to be extended to laboratory staff at district level by 2017
- Adoption and Integration of laboratory equipment standards based on Zambia Bureau of Standards (ZABS) by 2017 and regular calibration of equipment at ZABS by 2020.
- MOH to develop a mechanism for managing equipment calibration (including creation of equipment database at district level with main database at provincial level) by 2020

#### Specifics of the transition

##### *GRZ roles and responsibilities for tasks/activities*

<b>Task done by ZPCT II</b>	<b>Who would do it post transition?</b>	<b>Do they need capacity building to do this?</b>
Procurement of major testing platforms	Other stakeholders	
Procurement of motorbikes	GRZ	No
Equipment repairs for high cost routine testing platforms	GRZ with other partners	No
Facilitation of equipment servicing and repairs	Provincial Medical Equipment Officer and District Biomedical Equipment Engineers	Yes
Adhoc commodity procurements for sustenance of PCR EID testing activities.	GRZ with other partners	No
Procurements for Haemocue POC (microcuvettes)	GRZ with other partners	No
Fixed service contract for high cost PCR Support Equipment (Biosafety cabinets)	GRZ with other partners	No
Fixed service contract for high cost major PCR Platform (CAP/CTM96)	GRZ with other partners	No
EID DBS Courier System	GRZ with other partners	No
Servicing & repair of motorbikes	GRZ with other partners	No
Design of national standard operating procedures	GRZ with other partners	Yes

##### *Capacity strengthening needs*

- There is need to train the Provincial Medical Equipment Officer in laboratory equipment maintenance and repair beyond their current basic equipment maintenance skills
- There is need to procure more motorcycles for CD4 sample referral system
- There is need to train GRZ staff in good commodity management practices

- There is need to replace obsolete laboratory equipment
- There is need to train more District Biomedical Equipment Engineers. Currently only 27, the first trainees, are being trained and will graduate in June of 2015.
- There is also a need to train district laboratory scientists

#### *Procedural changes*

There are no significant changes that are needed to procedures in order to successfully transition aspects of the program element to GRZ as the project uses existing National Medical Laboratory Policy, GRZ SOPs, national guidelines, tools and other MoH approved materials.

The meeting proposed that equipment branding to include both GRZ and USAID logos in order to facilitate ownership by GRZ health facilities who would be motivated to be proactive when it comes to maintenance and repair of support equipment such as air conditioners and fridges.

The meeting also proposed that branding to include warranty, expiry date and warranty management should be handled by Provincial Medical Equipment Officer and District Biomedical Equipment Engineer

#### *Buy-in*

Based on the two buy-in meetings held with both the Permanent Secretaries of Ministry of Health and Ministry of Community Development Mother and Child Health, there are no indications of any resistance to the transition at that high level. Both officials endorsed the transition planning meeting whose objective was to develop a joint transition plan between GRZ and the ZPCT IIB project. The plan aims to identify program elements that can be transitioned to GRZ support. Both Permanent Secretaries emphasized the need to have a carefully thought out plan that should be implemented in phases with full GRZ participation. However, views expressed by senior officials at DCMO and PMO level where the project is implemented expressed anxiety about the potential negative impact of the transition. They noted the enormous gains made with support from ZPCT IIB and expressed apprehension about a hasty transition process that is not sufficiently backed up by adequate GRZ financial resources. The plan, therefore, is to continually engage MOH while emphasizing the phased approach of the transition over time.

#### *Outputs and outcomes*

##### ***Expected changes in the achievement levels for outputs or outcomes***

There are expected changes in the achievement levels for outputs or outcomes. The revision of the Zambia Consolidated Guidelines for Treatment and Prevention of HIV Infections to expand treatment eligibility to include all HIV-infected children and adolescents <15 years of age and infected adolescents ≥15 years old and adults with CD4 count ≤ 500, implementation of Option B+ and scale-up of TB/HIV activities in Zambia has implications for the expected increase in the volume people seeking HIV/AIDS services. This has implications for laboratory diagnostic services in Zambia. Many more people will seek HIV testing and need to be initiated on treatment.

In this regard, the follow-on project (D-SERVE) is expected to strengthen laboratory systems to support better HIV-related diagnostics and shortened turn-around times for all supported facilities in the six provinces in which D-SERVE will be implemented. D-SERVE is therefore expected to fund point-of-care

CD4 testing machines (PIMA or cell analyzer), viral load testing machines and TB confirmatory platforms, including quality-assured microscopy and GeneXpert mycobacterium tuberculosis/rifampicin (MTB/RIF) technology. D-SERVE will be expected to work with the provinces and other supply chain partners to provide laboratory supplies and technical assistance for laboratory improvements. The number of public health laboratories capable of conducting HIV/AIDS diagnosis and disease monitoring is expected to rise by 50% across supported districts in D-SERVE.

#### *Inputs*

Considering the level of investment required to achieve a 50% increase in the number of laboratories capable of conducting HIV/AIDS diagnosis and disease monitoring, it is not conceivable that GRZ will mobilize substantial financial resources to sustain the levels of support provided by the project before the end of D-SERVE.

The fact that there will be a follow on project to ZPCT IIB, and based on pronouncements at the Chaminuka meeting, it is safe to conclude that laboratory equipment and their maintenance, will continue to be supported by the projects (i.e. ZPCT IIB and D-SERVE) for the foreseeable future. Tools and materials are not expected to be adapted as the ones currently being used by the project conform to and are in line with GRZ SOPs, policy, procedures and practice.

#### *Quality assurance*

**Major and minor equipment procurement:** Proper procurement procedures were followed for the procurement of minor laboratory support equipment from MoH approved vendors. Major platforms were also procured based on MoH approved listing that distinguishes the different laboratories based at the different levels of health care and further specifies which platforms may be procured. Overall procurement integrity is assured by following FHI 360 and USAID rules and regulations for procurement of both categories of equipment.

**Performance of equipment:** The performance of equipment is verified through the laboratory technical working group that facilitates for the validation of all selected platforms consultatively (with all stakeholders) and adopts equipment for national use. End users in collaboration with partners track the operational performance at facility level and advise accordingly. ZPCT tracks the functionality of equipment through an equipment functionality tracking tool and further routinely reviews prescribed user maintenance procedures through documentation on the appropriate MoH approved logs. Vendor maintenance is tracked using the same tool and is used to prompt scheduled service. The quality assurance and quality improvement (QA/QI) tool also facilitates for tracking of equipment functionality during its scheduled administration and also verifies the availability of reagents critical for consistent laboratory testing.

**CD4 Sample Referral System:** As CD4 testing is critical for the ART and PMTCT programs ZPCT has introduced a number of crosscutting indicators that keep the project informed on CD4 testing access. For facilities that do not have immediate access to CD4 testing facilities referral of samples through the provision of motorcycles is in place and for accountability is tracked through fuel log sheets and routine servicing prompted as per supplier's requirements.

CD4 Related Indicators.

1. SI 24
2. SI 25
3. PMTCT 12f
4. PMTCT 12c
5. PMTCT 12b
6. VCT3
7. Lab 4c

**Standard Operating Procedures:** Regular reviews of SOP's will be required to keep them relevant to the practice. Reviews will be prompted by modifications to procedures, upgrades to equipment or introduction of entirely new methods.

**Logistics Management:** To assure the availability of commodities ZPCT ensures that facility staff are trained in the appropriate logistic systems i.e. Lab commodities or HIV Test Kit logistic systems. This to a large extent assures the availability of commodities on a consistent basis all factors being equal.

**HIV Early Infant Diagnosis:** The tracking of indicators related to EID or that have implications on EID will be critical for tracking the quality of service being offered for pediatric ART services. The following indicators are tracked:

1. PMTCT 30a
2. PMTCT 30b
3. PMTCT 30c
4. PMTCT30d
5. PMTCT30e

**DBS Courier System:** This will also be tracked and measured against the placement and eventual testing of DBS at provincial level.

**ADCH PCR Quality Assurance:** Regular audits of the PCR Laboratory at ADCH will be important to keep the implementation of quality management systems in check and in compliance with ISO 15189 requirements. These requirements are critical for the accreditation of the laboratory.

**Metrics to demonstrate milestone achievement**

- # of equipment serviced by vendor
- # of equipment being serviced by the PMEO and DBEE
- # of districts with Biomedical Medical Equipment Engineers
- # of districts reporting correctly and on time for lab commodities
- Turnaround time for equipment downtime
- # DBS samples sent and results
- GRZ deploys staff at Ndola PCR lab
- # of districts with functional specimen referral system

## Appendix F: Specifics on the transition plan for strengthening commodity management and ensuring uninterrupted stocks for HIV/AIDS services

Description of ZPCT program element

### *Intended outcomes*

This program element is meant to ensure effective and enhanced commodity management with a focus on commodity availability in support of HIV/AIDS service delivery. This also includes improved storage conditions for essential medicines and medical supplies and adherence to good pharmacy practice standards.

### **Measuring and monitoring accomplishments**

The project works with other stakeholders to check the national pipeline and eLMIS tool to monitor the supply chain at national level and stock imbalances and implements a robust redistribution subsystem to ensure stocks are equitably distributed and made available to all sites. The project implements the Monitoring, Training and Planning (MTP) approach that follows up trained HCWs in commodity management principles and the implementation of acquired knowledge and skills by HCWs at Service Delivery Point level.

### *Outputs*

ZPCT II procured the following pharmacy support equipment and requirements: computers (288), UPS (18), printers (539), air conditioners (215), pallets (112), lockable medicine cabinets (559), and medicine counting trays (319), refrigerators (156), fridge thermometers (216), room thermometers (333), and fire extinguishers (305). The project facilitated for the servicing and repairs for computers, UPS, printers, air conditioners, refrigerators and fire extinguishers and replaced obsolete equipment.

ZPCT II carried out refurbishments and/or renovations of Pharmacy store rooms and dispensaries over LOP including partitioning and storage shelving in some ZPCT supported facilities.

The project held three commodity management training events per quarter for 60 pharmacy and laboratory staff. A total of 998 were trained under ZPCT II, and a further 60 HCWs will have been trained under ZPCT IIB.

The project participated in the periodic revision of Pharmacy standard operating procedures (SOPs) by hosting 4 workshops and assisted with the printing of 2000 ZAMRA pharmacovigilance registers and other IEC materials.

The project procured commodities to support voluntary medical male circumcision (VMMC) services as follows: 8515 MC reusable instrument kits, 119, 017 MC consumable kits, 53,300 Lignocaine, MC medical supplies and assorted antiseptics every quarter per year, which has so far resulted in 104,753 circumcisions during LOP from static and outreach activities.

ZPCT II provided support for the regular holding of Drugs and Therapeutics Committee meetings in ZPCT supported districts and printed 154,539 pharmacy refill prescriptions for facilities requiring.

### *Processes*

1. **Procuring equipment for pharmacy departments:** The project first conducts a facility needs assessment using ZPCT general facility assessment tool for new sites to identify the status quo

and gaps.<sup>2</sup> The project then prioritizes needs based on budget availability and estimated service volumes, and plans and budgets for the procurement following procedures as mandated by USAID rules and regulations. The QA/QI tool is then administered every quarter initially and then twice a year (thereafter as sites are graduated) to monitor functionality and appropriate use.

2. **Equipment servicing and repairs:** ZPCT II provides finances for regular servicing and repairs for non-functional equipment once this has been discovered following site visits or reported by HCWs
3. **Pharmacy Refurbishments and renovations:** The project first conducts a facility needs assessment using ZPCT general facility assessment tool for new sites to identify facilities needing improved storage capacity and/or modified work space.
4. **Training HCWs in commodity management:** During routine mentoring and supportive supervision visits to facilities, ZPCT identifies staff who need training on general aspects of commodity management which includes pharmaceutical management cycle, rational use of medicines and medical supplies, quality assurance and management information systems. This training compliments the nationally approved training on logistic systems. ZPCT pays for the logistics and follows-up on the training during the project's routine mentoring/supervision visits.
5. **Review of SOPs:** Facilitating a series of consultative meetings/workshops with various stakeholders to review and update the current SOPs
6. **Providing pharmacovigilance support:** Consultative meetings with NPVU to review planned activities and deliverables to identify funding gap and thereafter allocating resources on ad hoc basis (budget allowing) to support some of the outlined needs
7. **Stop-gap procurement of ART and laboratory commodities to avoid stock-outs:** If an interruption in availability of national stocks is anticipated, the project will conduct an ad hoc procurement in response to the gap. The project identifies interruptions in advance by monitoring the pipeline using a commodity availability tracking tool and a GRZ tool called the supply chain manager.<sup>3</sup>
8. **Procuring male circumcision commodities:** The project monitors supplies at central level and identifies potential stock interruptions, looks at set MC targets and consumption data to quantify and forecast needs, source supplies directly, negotiates prices, places orders, or engages SCMS to procure on behalf of ZPCT II, receives consignments, assures the quality of products delivered, stores and distributes commodities to 55 MC sites
9. **Support for DTCs:** Ascertain availability and functionality of DTCs using the pharmacy QA/QI tools and setting aside some funds earmarked for clinical meetings in the RAs for this meeting to be conducted once a quarter per district.
10. **Providing Pharmacy Refill Forms:** Review of stock status at ART sites and procurement based on needs after quantification processes.

#### *Inputs*

- Procure pharmacy support equipment (air conditioners, refrigerators, lockable medicine cabinets, computers, fire extinguishers, medicine counting trays). \$636, 349
- Refurbishment of pharmacy storerooms and dispensaries (\$300,000) over five years
- Servicing and maintenance of equipment \$20,161/year

- Support to procurement of MC commodities (\$54,347)
- Review of SOPs for pharmaceutical services (\$21,774) over five years
- SOPs: printing, orientation and dissemination
- Support for facility Drug and Therapeutic Committee Meetings (\$200/per meeting/ year)
- Training in pharmacovigilance (Not supported)
- Printing of pharmacovigilance registers
- Commodity management training (\$290,000)

#### **Staffing levels required to perform the activity**

The establishment provides for the placement of pharmacists and pharmacy technologists to take up the delivery of pharmaceutical services however the staffing levels are inadequate and some of the facilities are run by other designated healthcare workers such as dispensers, nurses. ZPCT has employed a pharmacy technical officer in every provincial office who manages the pharmacy aspects of the programme. These are supported by 2 technical officers at HQ.

#### **Tools, materials, and equipment used to perform the activity**

MOH approved standard operating procedures, treatment guidelines, protocols, national formularies and medicines list are used to perform pharmaceutical management activities. For policy guidance, the project uses ART and PMTCT guidelines and protocols and the National drug Policy.

#### Related GRZ activities and initiatives

- GRZ procures some basic pharmacy equipment when budget allows
- Facilitates equipment servicing and repairs on identified equipment
- GRZ caters for new storerooms and dispensaries through construction of new health facilities
- Helps in identifying HCWs to be trained and assists with follow up of trained staff
- Takes the lead in facilitating workshops/meetings to review SOPs, medicines lists, guidelines, national formulary, drug policies and other documents
- Distributes pharmacovigilance registers and provides regular feedback on reported ADRs
- GRZ takes lead and participates in national quantification and forecasting for commodities
- Oversees commodity management of medicines and medical supplies at all levels
- Facilitates DTC meetings
- GRZ provides supportive supervision and mentorship of pharmacy staff

#### Proposed transition strategy, steps/phases/stages, and timeframe

- ZPCT IIB to hold further consultative meetings with Deputy Director Pharmacy Services (MOH) and equivalent at MCDMCH, to agree on how to proceed with transition plan
- Plan for joint technical assistance visits by Provincial and District Pharmacy Officers
- Consultative meeting on pharmacy mentorship program with both ministries and stakeholders
- Engagement of Chief Equipment Application Specialist (MOH, Lusaka ) to validate transition strategies discussed at Chaminuka meeting by April 2015
- Engagement of Provincial Medical Equipment Officer with ZPCT IIB provincial staff (PPM and PTA) for mapping out of preliminary strategies by April 2015
- Consultative/collaborative meetings with provincial pharmacist, district pharmacist and Provincial Medical Equipment Officer by April 2015.

- ZPCT II B to conduct quarterly joint visits (effective April 2015) with the provincial pharmacist, district pharmacist and Provincial Medical Equipment Officer to provide technical assistance and monitor equipment functionality, and determine repair and servicing needs.
- Explore use of Provincial Medical Equipment Officer to service air conditioners that are beyond warranty by April 2015
- Creation of joint provincial database to capture and manage all equipment at provincial level by August 2015
- Oversight of commodity status at district level fully managed by district pharmacists by 2017
- Pharmacy mentorship programs fully managed by PMO and DCMO by 2017

### Specifics of the transition

#### *GRZ roles and responsibilities for tasks/activities*

- GRZ to continue to provide overall policy guidance
- GRZ to take a lead in implementing facility based pharmaceutical support activities e.g. Drug and Therapeutic Committee meetings
- Partner to continue to provide some financial support for adhoc procurement of equipment and supplies in critical areas(e.g. MC supplies)
- GRZ to take a lead in monitoring of implementation plan

<b>Task done by ZPCT II</b>	<b>Who would do it post transition?</b>	<b>Do they need capacity building to do this?</b>
Procurement of basic equipment	GRZ/other partners	No
Equipment servicing and repairs	Provincial/District staff	No
Refurbishments/renovations	GRZ/other partners	No
Training/Mentorship	Provincial/District staff	No
Procurement of commodities	GRZ/other partners	No

#### *Capacity strengthening needs*

- There is need to train GRZ staff in good commodity management practices
- There is need to replace obsolete pharmacy equipment
- Train GRZ staff in pharmacovigilance
- Orientation and disseminate of SOPs
- Pharmacy mentorship program

#### *Procedural changes*

There are no significant changes that are needed to procedures in order to successfully transition aspects of the program element to GRZ as the project uses existing National Policy, GRZ SOPs, guidelines, tools and materials. The meeting proposed that equipment branding to include both GRZ and USAID logos in

order to facilitate ownership by GRZ health facilities who would be motivated to be proactive when it comes to maintenance and repair of support equipment such as air conditioners and fridges.

The meeting also proposed that branding to include warranty, expiry date and warranty management should be handled by Provincial Medical Equipment Officer and District pharmacists and a joint inventory database for equipment.

#### *Buy-in*

Based on the two buy-in meetings held with both the Permanent Secretaries of Ministry of Health and Ministry of Community Development Mother and Child Health, there are no indications of any resistance to the transition at that high level. Both officials endorsed the transition planning meeting whose objective was to develop a joint transition plan between GRZ and the ZPCT IIB project. The plan aims to identify program elements that can be transitioned to GRZ support. Both Permanent Secretaries emphasized the need to have a carefully thought out plan that should be implemented in phases with full GRZ participation. However, views expressed by senior officials at DCMO and PMO level where the project is implemented expressed anxiety about the potential negative impact of the transition. They noted the enormous gains made with support from ZPCT IIB and expressed apprehension about a hasty transition process that is not sufficiently backed up by adequate GRZ financial resources. The plan, therefore, is to continually engage MOH while emphasizing the phased approach of the transition over time

#### *Outputs and outcomes*

There are expected changes in the achievement levels for outputs or outcomes. The revision of the Zambia Consolidated Guidelines for Treatment and Prevention of HIV Infections to expand treatment eligibility to include all HIV-infected children and adolescents <15 years of age and infected adolescents ≥15 years old and adults with CD4 count ≤ 500, need for community dispensation of ARVs, implementation of Option B+ and scale-up of TB/HIV activities in Zambia has implications for the expected increase in the volume of people seeking HIV/AIDS services and the need for adequate orientation in dispensing practices and medication use counselling at community level. This has implications for pharmaceutical services in Zambia as many more people will be initiated on treatment.

In this regard, the follow-on project (D-SERVE) is expected to strengthen pharmacy systems to support better healthcare services delivery for all supported facilities in the six provinces in which D-SERVE will be implemented. D-SERVE is therefore expected to strengthen pharmaceutical services with regards commodity management and rational use of medicines and medical supplies as well as explore the concept of health shops for enhancement of community dispensing of ARV drugs. D-SERVE will be expected to work with the provinces and other supply chain partners to ensure adequate and constant provision of medicines and medical supplies and mentorship and supportive supervision of pharmacy staff and other designated HCWs. As a result the output is expected to be higher.

#### *Inputs*

Considering the level of investment required to ensure delivery of quality pharmacy services, it is not conceivable that GRZ will mobilize substantial financial resources to sustain the levels of support provided by the project before the end of D-SERVE.

#### *Quality assurance*

Use of the Quality Assurance/Quality Improvement Tool (QA/QI) to monitor and maintain quality

Ensure proper procurement procedures by following FHI 360 and USAID rules and regulations for procurement. During supervision visits, project staff check on functionality and follow up of periodic equipment service by appropriate vendors.

Engagement of the infrastructure officer to ensure building specifications are followed and adhered to and working with recognized and reputable contractors

Following GRZ laid down procedures and standards for service provision

Regular reviews of SOP's will be required to keep them relevant to the practice.

## Appendix G: Specifics on the transition plan for providing IT TA support and equipment for information systems

Description of ZPCT program element

### *Intended outcomes*

ZPCT provides IT equipment, IT technical support and maintenance to MOH/MCDMCH for enhanced patient monitoring and continuity of care, and to support monitoring and evaluation program activities. Health facilities are equipped with computers, printers, UPS, 3G data modems and networking of various service delivery points in the health facilities. ZPCT provides regular quarterly visits to monitor functionality of IT equipment, provide technical support and maintenance of applications and software. Data Entry Clerks placed in the selected health facilities also monitor the status of IT equipment and systems and notify the ZPCT provincial offices of any faults that need urgent attention. The provincial IT helpdesk officer travels to health facilities as and when faults are reported, in addition of course to the routine quarterly support visits.

### *Outputs*

**The following are the outputs for ZPCT IIB:**

ZPCT has procured and supplied the following to health facilities:

- 237 Computers
- 195 Printers
- 234 UPS
- 52 facilities networked
- 22 facilities have access to the web2sms technology
- 137 facilities installed with SmartCare

### *Processes*

1. **Facility assessment:** ZPCT staff in collaboration with GRZ staff conduct facility assessments to come up with IT equipment needs.
2. **Procurement:** Using ZPCT procurement processes, the identified equipment are purchased
3. **Preparation before installation:** when IT equipment is delivered to IT Helpdesk Officers who receive them, install applications, updates and tests the computers before delivery to the facilities. This is done by IT staff at provincial ZPCT offices.
4. **Networking:** Where needed in such sites as model sites, Cable or wireless networks are setup to enable software applications such as SmartCare write data to a single database. This is done once by ZPCT IT staff.
5. **Facilitate data transfer:** Installation of GPRS/3G data modems for data transfer and SMS notification services for ART clients is also done by ZPCT staff.
6. **Technical support:** IT Helpdesk Support Officers provide regular visits every quarter for technical support and maintenance of applications and software.
7. **Maintenance:** IT Helpdesk Support Officers provide regular visits every quarter for technical support and maintenance of applications and software. They visit each site at least once a quarter. Sometimes adhoc visits are done in cases of need for repairs. Virus updates for site with no

permanent internet access are sent to sites every month with data collection teams from the SI unit or IT helpdesk officer on scheduled trips.

8. **Fault identification:** The data associates in the facilities identify faults and report to the provincial ZPCT staff responsible for IT (IT Helpdesk Officer). This officer then travels to the facility to attend to the reports.

These officers are trained in the applications that they will use such as SmartCare. Each Provincial ZPCT Office has one Helpdesk Officer who devote **30%** of LOE to provision of TA to the facilities.

### Inputs

#### Project Costs

Cost component	How many needed per year	Cost per unit	Estimated annual Cost/budget
IT equipment	59 (average over the 4 years)	K7,400.00	K436,600.00
	49 (average over the 4 years)	K2,000.00	K98,000.00
	59 (average over the 4 years)	K1,600.00	K94,400.00
	59 Software licenses	K300.00	K17,700.00
Internet access	79 Modems (K140/per modem/month)	K11,060.00	K132,720.00
Facility assessment	Once per year (10 days x 5 provinces )	K8,000.00	K40,000.00
Facility support visits	4 Quarterly visits of 10 days per province	K40,000.00	K160,000.00

#### Staffing

- 5 IT Helpdesk Support Officer (1 per province)

#### Tools, Material and equipment

- Facility Assessment tool
- Software /antivirus updates
- IT equipment tracking tool

#### Related GRZ activities and initiatives

GRZ has finalized its IT policy and guidelines which are supposed to guide all IT support in the health sector. GRZ has also employed Provincial ITC Officer (PICTO) through donor support and also relies on the District Health information officers to provide basic ICT support at district and facility level.

#### Proposed transition strategy, steps/phases/stages, and timeframe

To transition ZPCT support for IT and information systems, the general strategy would be to decentralize this service to district level with supervision from provincial level. This could first be done by identifying and strengthening what GRZ is already doing and supporting IT in line with the GRZ ICT guidelines. This might be in the initial 10 districts and rolled out to the districts once proven to be successful and cost effective.

### Ideas on specific elements of this strategy:

To be able to do this effectively, ZPCT would need to initiate and strengthen decentralization of the IT equipment maintenance. This would include the following steps:

1. Making deliberate efforts by the Provincial ZPCT staff to work with the GRZ counterpart, PICTO, to visit the supported sites where possible.
2. Developing and training DHIOs in basic IT skills to equip them to handle basic to be able to maintain ICT equipment, provide updates for antivirus software, troubleshoot and resolve common problems and know when to refer to the PICTO for more serious problems and repairs.
3. Encourage integration and use available opportunities such as for data collection to do some routine maintenance.
4. Support GRZ with funds to enable these visits to facilities, in the recipient agreements
5. Conduct joint trips with the PICTO or include some support for the trips to provide TA to DHIOs or maintain and repair IT equipment.
6. Provide updates to DHIOs to enable them to maintain all IT equipment and not just ZPCT provided equipment
7. Continue to identify facility IT needs in collaboration with GRZ.

### Specifics of the transition

#### *GRZ roles and responsibilities for tasks/activities*

#### **Post D-SERVE transition vision**

Complete integration of IT Support processes with government IT support systems and standards.

#### **GRZ roles and responsibilities for tasks/activities post transition**

<b>Task done by ZPCT II</b>	<b>Who would do it post transition?</b>
Receive new IT equipment	PICTO
Test it to ensure it works	PICTO
Prepare the equipment for use by installing software	PICTO
Install the equipment	PICTO
Provide updates for the equipment	PICTO/ DHIO
Conduct routine maintenance of equipment	PICTO/ DHIO
Trouble shooting for problems	DHIO
Repairing damaged equipment	PICTO
Provision of data management tools such as SmartCare, antivirus applications etc.	PICTO/ DHIO
Installation and maintenance of networks for integrated SmartCare in facilities	PICTO
Providing technical expertise at district level	PICTO

#### **Timing/milestones:**

What could be achieved <b>by the end of ZPCT IIB (Sep 2015):</b>
<ul style="list-style-type: none"><li>• Develop IT training plan and curriculum/Manual for DHIOs to equip them with skills to take care of common IT hardware and software and Network issues.</li></ul>
What could be achieved in the <b>first year of D-SERVE (Sep 2016):</b>

- Align IT equipment purchased under D-SERVE to comply with GRZ IT equipment standards.
- Begin DHIO IT staff development trainings starting with 10 districts.
- ZPCT helpdesk support officer to provide accompaniment to DHIOs on co-planned IT support visits to facilities.

What could be achieved **by the mid-term of D-SERVE (Mar 2017):**

- **Roll out** DHIO IT staff development trainings to the remaining DHIOs in remaining districts.
- Reduce support visits to facilities by 50%
- Include GRZ staff(i.e. PICTO or DHIO) in all assessments/planning for IT equipment and networking at supported facilities

What could be achieved **by the end of D-SERVE (Sep 2020):**

- 100% IT support provided by GRZ staff

#### *Capacity strengthening needs*

- DHIO ICT training using a specially developed training package to equip them with basic IT skills to take care of common IT hardware and software and network issues which could begin in the ZPCTIIB project.
- Setting up IT standards and policies according to GRZ ICT guidelines and policies
- Planning, managing and leveraging resources for IT equipment maintenance visits to sites
- Maintaining, monitoring use and managing donor purchased IT equipment using the same stringent rules and regulations of use for such equipment.

#### *Procedural changes*

There are not many changes that will have to be made as these processes are already happening in the GRZ ICT system. The project will only support and strengthen existing systems. In this transition plan, DHIOs will be empowered with skills and knowledge to manage basic IT problems some of which they already attend to.

#### *Buy-in*

There are no potential contentious issues in this programme area.

#### *Outputs and outcomes*

Initially with more GRZ involvement in joint visits, the level would be maintained. As more DHIOs are trained in basic IT skills, more maintenance would be done in this decentralized model with additional donor funding. As GRZ incrementally plans and budgets for maintenance of IT equipment, there would be more outputs.

#### *Inputs*

In the transition period, most of the visits and maintenance would be paid for by the project with GRZ also contributing towards this through their routine grants. It is expected that this proportion would increase over the life of D-SERVE. GRZ procures IT equipment which it distributed to its institutions which also

purchase IT equipment from their grants if planned for. Maintenance of this equipment is done by the PICTO.

*Quality assurance*

The availability of GRZ ICT policies and guidelines and their rigorous enforcement will maintain quality of ICT maintenance.

## Appendix H: Specifics on the transition plan for training, placing, and supporting community volunteers to support HIV/AIDS services

Description of ZPCT program element

### *Intended outcomes*

This element is meant to fill in the human resource gap and lighten the work burden of health care workers. The volunteers have dual a role which are:

- (1) Task shifting/Sharing to fill in the human resource gap at healthy facility level.
- (2) Demand creation to promote access to community based HIV/AIDS services.

The ZPCT IIB project has a built in community monitoring system, where the level of effort by the community volunteers is measured by the number of people referred and reporting at the facility. Volunteers work 3 days per week, two (2) days at the facility to assist with facility-based HIV/AIDS activities and one is for outreach activities to create demand for and promote access HIV/AIDS services. The project tracks the attendance of volunteers through a daily logging system supervised by health facility staff. The attendances of volunteers is validated by the ZPCT IIB staff.

### *Outputs*

ZPCT has trained and placed 1,419 Community Volunteers in 400 health facilities in the 6 supported provinces. They are trained by MOH certified trainers before placement either as Adherence Counselors, Lay CT or PMTCT Counsellors. Refresher trainings are provided every two years.

In 2014, volunteers motivated 887,650 clients to access various HIV/AIDS services and out of these 751,041 actually accessed the services. The 1,419 volunteers contributed 17,028 man hours which is equivalent to 774 health care workers this is on assumption that health staff work for 22 days in a month.

### *Processes*

TASK	TIMEFRAME				
	Beginning	Half Yearly	Yearly	Every 2 Years	Ongoing
Pre- service training	X				
Facilitate Placement of volunteers	X				
Provide Job aids	X	X			
Support in-charges to manage Community Volunteers	X	X	X	X	X
Supervision of Volunteers	X	X	X	X	X
Managing Community Data	X	X	X	X	X
Organize Refresher training				X	

### *Inputs*

Activity/Item	No. required	Frequency	Unit cost	Total cost
Pre-service training-each volunteer	1,419	1	3,171	4,499,649

In-service training-Each volunteer	1,419	1	1,585	2,249,115
Job aids/IEC materials	2,400	1	15	336,000
Bicycles	1,200	1	583	700,000
M&E stationary	assorted			72,282
Transport reimbursement	1,419	12	150	2,554,200
Lunch allowance	30	4	50	6,000
Rain gear	1,419	1	240	350,150
Supervision	22	4	1,200	105,600
<b>TOTAL</b>				<b>10,572,996</b>

To perform this task, the project has employed fifteen (15) staff: ten (10) at provincial level and five (5) at national level. These are the Program Manager, two (2) Program Management Advisors (Community Mobilization and M&E), the Grants coordinator, five (5) Program Management Coordinators and five (5) Development Coordinators.

To perform various tasks, the ZPCT II staff are provided with computers, pool transport and access to internet. On the other hand, the Community Volunteers are provided with transport refund, meal allowance during outreach activities, rain gear and stationary (referral forms, note books and pens), courier bags and bicycles.

#### Related GRZ activities and initiatives

Currently GRZ is providing a minimum 10% budgetary allocation for community activities at each district health office. GRZ through MCDMCH supports CBVs during outreach activities by providing lunch to the volunteers. They train, coordinate & supervise volunteers at health center level. GRZ is currently revising Community Health Workers strategy to encompass community volunteers. They are also working on harmonizing volunteer management and compensation among stakeholders. Through the Clinton Health Access Initiative (CHAI), GRZ is training Community Health Assistants who have been put on GRZ payroll in some districts and are collecting community data.

The absence of community Volunteer structure and policy will have serious implications for the transition. GRZ just developed a community health workers policy which does not accommodate community volunteers. It is unlikely that they will initiate another review in the near future.

The Community Health Workers strategy GRZ is currently pursuing does not attend to community volunteer needs. The Reinitiated Community Health Workers are not volunteers but salaried public service workers, although, GRZ insists that they are a link to community volunteers. GRZ is interested in a cadre that is polyvalent, unlike community cadres trained for a specific function.

#### Proposed transition strategy, steps/phases/stages, and timeframe

Before support for these cadres of community volunteers can be transitioned to the GRZ, the project will have to:

- 1) Work with GRZ to appreciate how these cadres fit into a coherent system of community volunteers,
- 2) Institutionalize management of these cadres into GRZ procedures and guidelines (such as including supervision of these cadres into the job descriptions of EHTs),
- 3) Strengthen capacity of managers and health workers for managing and supervising these CVs,

- 4) Provide transitional results-based financing (perhaps matching GRZ contributions) for GRZ management of these cadres, and
- 5) Once fully institutionalized and effectively managed, gradually transition financing of these CVs away from the project (GRZ, other donors, direct financing from USG, user fees, insurance schemes, etc.).

Sharing the database of community volunteers and tools used by ZPCTIIB with MoH and CDMCH will be done by end of April 2015. Under D-SERVE, management and support activities should be transitioned completely in one or a few districts to start, supported by a results-based grant/contract from the project..

#### Specifics of the transition

##### *GRZ roles and responsibilities for tasks/activities*

	Key Activity	Responsible officer
1	Receive and review ZPCTIIB community volunteers database and ZPCT monitoring tools	MoH/MCDMCH
2	Development of concept notes on how these cadres fit into a coherent system of community volunteers and for possible inclusion in GRZ structures.	MoH/MCDMCH/ZPCTIIB (selected Committee)
3	Harmonization of performance based financing	DCMOs
4	Institutionalize management and financing of CBVs	DCMO
5	Up grading of CBVs to Community Health Assistances	DCMO
6	Institutionalize management of these cadres into GRZ procedures and guidelines (such as including supervision of these cadres into the job descriptions of EHTs)	MoH/MCDMCH

##### *Capacity strengthening needs*

GRZ may need capacity strengthening in developing and formalising the data collection, reporting, analysis and use of information on these Community Volunteers in the routine information systems (i.e. HMIS and SmartCare). In addition, the capacity of District managers and health workers to manage and supervise these CVs may need strengthening. There will be need for enhanced capacity in identifying community volunteer training needs done through an initial assessment to determine capacity enhancement needs before designing the capacity enhancement strategy with GRZ which the project could finance. The project would then determine and help to address capacity building needs, document the capacity strengthening needs and process to inform scale-up and sustainability. This can begin in the first year of D- SERVE.

### *Procedural changes*

There is a system of volunteers used by GRZ in place where they do not receive similar direct support as the project volunteers. Employing or supporting the community volunteers by GRZ will be a significant change depending on the outcome of the community volunteer strategy GRZ is currently working on. This might include changes in the structures at facility level, community volunteer support provided by the system, and whether they will be employed or not. The other change might need to be the institutionalization of management and support for these cadres of CVs into district and facility procedures and roles. One could be the inclusion of managing the community volunteers in the job descriptions of the responsible facility staff such as the EHT. Another would be to include community volunteers in management procedures (planning and budgeting, data reviews, etc.), and clearly determining the roles and responsibilities of district and facility staff to prepare them take over the management function of community volunteers. This could begin with a few willing districts to develop the model, before scaling up to other districts.

### *Buy-in*

GRZ operates within stipulated policies and guidelines and in the absence of funded positions in the GRZ establishment for community volunteer, the transition of this cadre to GRZ may may not happen in the foreseeable future. Therefore ZPCT needs to work with GRZ to formally recognize in policy the importance of these cadres of community volunteers for service delivery, as part of a coherent system of community volunteers; find out the outcome of the review that was conducted by the MCHMCH on such issues; find out what guidance/direction they produced; convince all key actors of the importance of these cadres, the project will need to produce evidence on their contribution, and communicate it effectively to key actors to build political support. Facilities will be allies (some facilities even started paying when project stopped for a while).

There could also be some resistance from the community volunteers themselves who have known the GRZ system of voluntary work to have less support than the project. Donors may have to get together to develop sustainable models for supporting volunteer work in GRZ facilities.

### *Outputs and outcomes*

It is expected that in the transition, outputs may be affected downwards i.e. volunteers who leave the service due to various reasons may not be replaced in time. Quality of services provided by health workers may be affected by work-overload which may result in burn-out. The demand for and access to HIV/AIDS services may decline creating room for increased HIV infection in the community.

### *Inputs*

The Project will design results-based financing arrangement for providing funding to the districts to manage, supervise, and provide the inputs needed by these cadres of CVs. The project would need to develop clear outputs and quality standards for these cadres CVs which could be routinely measured and independently verified, and would incentivize districts and facilities to effectively manage and support the work of these cadres. This financing would be an interim arrangement which would allow for these CVs to be institutionalized into the GRZ system, laying the groundwork for eventual GRZ (or other) financing. To manage this cadre, donors may have to provide support beyond D-SERVE.

Initially any equipment for the volunteers would be paid for by the project with incremental contributions from GRZ over time. The GRZ system of maintaining bicycles and any similar equipment would be used for these items.

Adoption of the community monitoring system and other tools used by the project into the GRZ system will depend on the GRZ model of inclusion of the community volunteers in the GRZ community volunteer's strategy that it is currently working on. GRZ currently has some tools which can then be harmonized with the project tools which can begin in the first year of D-SERVE.

#### *Quality assurance*

To maintain quality, all community volunteers must be trained in appropriate service areas and periodical receive refresher training and orientation for new updates. Trainers must continue using MOH approved manuals for trainings and volunteers should be provided with job-aids and IEC materials to assist them do their work correctly. GRZ must monitor and supervise the work of volunteers at both facility and community level.

## Appendix I: Specifics on the transition plan for human resource management – DECs

Description of ZPCT program element

### *Intended outcomes*

This program element is meant to provide Data Management support for HIV/AIDS service delivery, including support for Data Entry Clerks (DECs), training and capacity building, data capture and reporting, stationery and other supplies as required. Support in this area is meant to fill in an identified human resource gap. The project has employed and supports 180 Data Entry Clerks who are attached to 140 health facilities in ZPCT IIB supported districts. The DECs collect and manage data which is analyzed, interpreted and used for improving HIV/AIDS program needs and service delivery. The DECs are regularly trained, refreshed & mentored in data management for HIV/AIDS services on a routine basis to assure the quality of data being collected. To facilitate these outcomes, the program provides computers, stationary (registers and smart care forms), internet support and filling cabinets. The project also pays the salary and fringe benefits for the Data Entry Clerks.

ZPCTII has produced an M&E procedure which has tools used to check the data quality, completeness and timeliness on a routine basis. Technical and program team members review project data and are informed to ensure smooth program implementation to reach desired goals.

Thus far, the project has accomplished the following:

- ZPCTII B data management support resulted in the development a system for routine collection, analysis, interpretation and use of data for improving HIV/AIDS program needs and service delivery.
- Training & mentorship support in the M&E component to all Health Care Workers and Data Entry Clerks.
- ZPCTII B M&E system provides data for monthly and quarterly data review meetings to facilitate decision making at all levels
- Provides transport and internet services for data transmission

### *Outputs*

This program element on support to Data management had the following outputs:

- 180 Data Entry Clerks were employed and provide data entry support in 140 health facilities
- 57 districts conducted semi-annual and annual Data Quality Assessments
- Maintained a constant supply of stationery for HIV/AIDS services data collection at 450 health facilities, including SmartCare forms, ANC client's cards and registers for all services.

### *Processes*

- **Capacity building:** The DECs are trained, refreshed & mentored in data management for HIV/AIDS services on a routine basis to assure the quality of data being collected. The DECs enter data on a monthly basis into ART registers and Smartcare database from which routine monthly reports are generated and other ad-hoc reports as needed by facility managers. The reports complement the HMIS reports. This data facilitates programme performance monitoring by both ZPCT and the health facilities. The project also provides support equipment including computers, internet

modems, as well as stationary (registers and smart care forms) and filling cabinets. The project also pays for the salary and fringe benefits for the Data Entry Clerks.

- **M & E training:** The project M&E team conducts training & mentorship support in data management for HIV/AIDS services to all HCWs and Data Entry Clerks i.e. trains them in the M&E part of all clinical trainings. Mentorship visits are done on a quarterly basis to all health facilities. In addition, refresher trainings are conducted when there are changes in data requirements e.g Option B+ and/or when new health care workers have been employed.
- **Data Quality:** The project has produced a Data Quality Assessment procedure which is used twice a year to check the quality of the data and assist to identify and resolve data quality issues and challenges. A Data verification protocol developed by ZPCTIIB is used by the DQA team to conduct the routine assessments.
- **Data review:** At the health facility level, facility managers are provided with monthly data for use in informing facility meetings and to help guide the implementation of service delivery. The provincial project office conducts routine quarterly Data Review Meetings to facilitate decision making and inform project implementation.
- **Data capture and transmission:** In addition to procuring stationery for data capture at health facility level, the project also provides transport and internet support for data collection and transmission between the three levels: health facility, district, provincial and national level.

TASK	TIMEFRAME					
	Beginning	Qtr1	Qtr2	Qtr3	Qtr4	Yearly
Pre- service training	X					
In- service training (DECs)				X		x
Placement of DECs	X					
Provision of logistics	X					
Supervision of DECs	x	X	x	X	X	
Data Quality Assessments			x		X	
Refresher training					X	x
Provision of stationery and other supplies	x	x	x	x	X	x

### *Inputs*

The project employs 180 Data Entry Clerks. However, the requirements will increase in the coming years: 100 more DECs will be required in the next five years under D-SERVE.

To maintain a good M&E system, a number of inputs will be required including: registers, smart care forms, computers, internet modems and subscription, filling cabinets, transport and fuel. The following is a detailed list:

- Employment of Data Entry Clerks: salaries and fringe benefits
- Training & mentorship support in M&E for HCWs and DECs; all DECs are re-oriented every year to be in line with routine updates to national guidelines and data reporting requirements.
- Quarterly TA visits to all health facilities in 57 districts
- Data Quality Assessments –twice yearly

- Transport and fuel; plan for monthly visits to all health facilities in the 57 districts
- Procurement of internet modems and subscription – 450 modems plus monthly subscriptions for data bundles
- Procurement of stationery – 15 registers for 45 and Smart care forms for estimated 230,000 active clients
- Over 2000 filing cabinets have been bought and placed in health facilities. However, the project anticipates additional 500 cabinets yearly because of expansion of services and increases in client volumes. It is worth noting that the issue of inadequate space for placing filing cabinets has reached crisis proportion in some facilities and needs urgent attention.

Activity/Item	No. required	Frequency	Unit cost	Total cost
Pre-service training	180	1	4,080	734,400
In-service training-Each Data Entry Clerk	180	1	4,080	734,400
Data Entry Clerk salaries	180	12	5,830	12,592,800
Registers	450	1	50	337,500
Smart Care forms	230,000	12	0.05	138,000
Transport & Fuel (quarterly)	57 (districts)	4	1,500	342,000
Internet Modems and subscriptions (monthly)	450	12		
Conduct data quality assessments	57 (districts)	2	680	77,520
Filing cabinets (yearly)	1000	1	1,900	1,900,000
<b>TOTAL</b>				

#### Related GRZ activities and initiatives

The GRZ has a Health Management Information System (HMIS). This program falls under the health status subsystem of the HMIS. The routine HIMS activities pertaining to this may be listed as follows:

- GRZ has established positions of District Health Information Officer (DHIO), Health Information Officer (HIO) and Records Clerks to support HMIS. However, the staffing establishment for these cadres is inadequate for the task.
- The DHIO Coordinates and supports data collection and reporting at district and facility level.
- The HIO position is found at District Hospital level and Records Clerks at selected health facilities. The DHIO supervises HIOs and Records Clerks who are based at selected health facilities.
- It has been noted that some DCMOs have converted other positions such as those meant for cleaners or Classified Daily Employees (CDEs) and used the positions to recruit Data Entry Clerks.

There is an existing two year employment freeze communicated by GRZ and will in the short term affect any suggestions for expansion of the GRZ workforce.

#### Proposed transition strategy, steps/phases/stages, and timeframe

To transition ZPCT support for data management, the general strategy would be to support the data entry clerks. This could be done by providing support for their salaries and consumables initially before coming to an agreement with government to begin to increasingly proportionally “co-fund” these expenses every year.

The transition strategy for the Data Management element will include the following:

- Development of a concept note for Data Entry Clerk position by April 2015
- Ring fence fuel for data management for DHIO which can increase report completeness and also integration as other data collected
- Continue to support stationery needs
- Share lessons learnt with districts that successfully placed DECs on the payroll
- Explore funded positions and possibilities of opening up frozen positions, how this relates to employment freeze, possibility of incremental engagement of DECs into GRZ salary structure over a number of years and according to GRZ priority
- Consider cost sharing for consumables the DECs use as an initial step to ownership
- Streamline reporting to include DHIOs receiving reports as well as ZPCT
- Inclusion of data review meetings as deliverable for recipient agreement to institutionalize them
- Clarify the role of the DMS/SHIO and DHIO in the supervision of the DECs
- Conduct capacity building for current/serving Records Clerks
- Institutionalize GRZ financing of the Data Entry Clerk position
- Share M&E system database and related tools
- Employment and deployment of M&E Officers by GRZ to operate at district and provincial level

*GRZ roles and responsibilities for tasks/activities*

	Task done by ZPCT II	Who would do it post transition?	Do they need capacity building to do this?
1	Development of concept notes for records clerk / DECs position for possible inclusion in GRZ structures	GRZ	YES
2	Deployment of M&E Officers at district and provincial health offices	GRZ	YES
3	Employment of Data Entry Clerks: salaries and fringe benefits	GRZ	NO
4	Training & mentorship support to DECs	GRZ	NO
5	Quarterly TA visits to all health facilities in 57 districts	GRZ	NO
6	Conducting Data Quality Assessments	GRZ	YES
7	Provide transport and fuel for monthly data collection at district level	GRZ	NO
8	Provide Internet modems and payment of subscriptions for data bundles	GRZ	NO
9	Procurement of stationery ( registers and client forms)	GRZ	NO
10	Procurement of filing cabinets and securing space	GRZ	NO

*Capacity strengthening needs*

The main capacity strengthening will include: DEC training; data collection, processing, and storage which will be done within the first year of D- SERVE. The Project will conduct assessments to determine specific

needs before designing the capacity enhancement strategy for GRZ. Specifically, the activities will be as follows:

- Needs assessment to identify gaps for capacity enhancement
- Conduct master trainers at district level of M&E trainings
- Training Record Clerks who can cover all areas including HIV/AIDS services.
- Develop a concept note to spearhead discussions on employment of DEC's with MOH/MCDMCH at national level
- Hold joint planning and M&E activities with PMO and DCMO.
- GRZ might consider establishing positions of M&E officers at DCMO and PMO and two to three Data Entry Clerks to support data collection within the district. These DEC's would be zoned within the district and each be responsible for data collection at a number of health facilities.

#### *Procedural changes*

The following were noted as key procedural changes:

- Use of DHIOs to supervise DEC's
- Supporting DHIOs to mentor and provide TS to the DEC's on a monthly basis as they collect data
- Conduct regular coordination and update meetings with MOH and MCDMCH during transition
- Joint planning for M & E activities

#### *Buy-in*

The project does not anticipate any resistance from any actors. However, GRZ operates within stipulated policies and guidelines and in the absence of commitment at national level, we can anticipate delays in assimilation of the concept behind transition.

#### *Outputs and outcomes*

It is expected that in the transition, outputs may be initially negatively affected – mainly in terms of the quality of data provided by health workers. This may affect management of the HIV/AIDS program and ultimately the quality of care for clients. In the long run, it is anticipated that systems will reach normalcy as GRZ increases allocation of resources for data management and initial capacity building efforts mature.

#### *Inputs*

The GRZ has suggested a very lean human resources structure to support data management. The rest of the inputs will be leveraged with resources already available under the mainstream HMIS.

All data management equipment bought with project funding will be handed over to GRZ. However, the project will provide GRZ with cost estimates of all equipment (purchase and maintenance) and projections for future needs to ensure they are provided for in annual work plans and budgets at national, provincial and district levels as needed.

As part of the transition process, respective technical departments (M&E and Human Resources) will conduct meetings to adopt and adapt data management tools. This harmonization process will assist with

institutionalization of data management tools by GRZ or at the least used by GRZ staff in the project area to assure a seamless transition of the project and sustain achievements scored thus far.

*Quality assurance*

All DEC's must be trained in data collection and management before deployment .Periodically they should receive refresher trainings as need arises. On quarterly basis, Data quality Assessments should be conducted.

## Appendix J: Specifics on the transition plan for facility renovations

### Description of ZPCT program element

#### *Intended outcomes*

ZPCT IIB works with MOH/MCDMCH to refurbish health facilities in order to provide a conducive environment and adequate space for the provision of HIV/AIDS and related services. Including infection control. The majority of facilities that are refurbished are often in a state of disrepair and do not have adequate space; demand for HIV/AIDS services continues to outstrip available space.

ZPCT support in the area of renovations has created space for service provision i.e. ART consultation rooms, CT rooms, PMTCT rooms, laboratories, pharmacies, dispensaries, DEC offices, maternity and general waiting shelters as well as improved sanitary conditions and infection control.

#### *Outputs*

ZPCT II has refurbished 260 health facilities and 15 new construction works since 2009 in the 6 Northern provinces of Zambia at a total cost of K15, 576,948. ZPCT IIB is currently in the process of refurbishing 16 additional facilities at an estimated cost of K1, 277,737.

#### *Processes*

ZPCT staff in liaison with DCMO staff identify facilities in need of refurbishment in order to create a conducive environment and/or to create additional space for service provision. Once joint facility assessments are conducted, refurbishments are prioritized and executed based on available budget, practical feasibility and existing space availability. Once the sites have been selected, BOQs and implementation plans for each facility are developed. A rigorous USAID approved tendering process is used to award a contract to the successful contractor. Provincial ZPCT II and DCMO staff then handover the site to the contractor to commence refurbishment works. The ZPCT Infrastructure Support Officer and personnel from the Ministry of Works make four site inspections for quality assurance and contract compliance. The refurbishment process takes a maximum of 6 months (average of 4) from assessment to handover of a refurbished facility. Quality control measures for refurbishments include 1st, 2nd, 3rd and 4th site inspections (i.e. certification for interim payments and final certification of practical completion and to ensure quality and adherence to specification). Health facility staff also continuously monitor the works and regularly update both the DCMO and ZPCT.

#### *Inputs*

#### **Project Costs**

<b>Cost component</b>	<b>How many needed per year (per district/facility)?</b>	<b>Cost per unit</b>	<b>Estimated annual Cost/budget</b>
Funding refurbishments	Once annually for approx. 70 refurb (total of refurbishment budget)	\$51,042 (K357,300)	\$3,373,000 (K25,011,000)
Facility assessment	Once annually per refurbishment	\$428 K3,000	\$30,000 K210,000
Tendering administration	Once annually per refurbishment	Tender document sold at approx	\$20,000 (K140,000)

		\$29 (K200) each	
Administration	Continuous	N/A	N/A
Site inspections	At least 4 site inspections per refurbishment	\$428 K3,000	\$30,000 K210,000

**Staffing**

- 1 infrastructure Support Officer per province

**Tools, Material and equipment**

- Facility Assessment tool/form and implementation plan (ZPCT)
- Environmental Site Assessment Form
- Bill of Quantities (international standard), architectural drawings and tender documents
- Refurbishment contract (We use FHI 360 Firm Fixed Price Contract)

*Related GRZ activities and initiatives*

GRZ has an Annual Infrastructure Operational Plan and a 5 years Investment and Modernization Plan but funding is too limited to meet the health infrastructure needs given the increasing population and disease burden in particular the increasing demand for HIV/AIDS services. Approximately K1,000,000 per province is allocated annually for general refurbishments (construction?) in the health sector but this is too limited and most health facilities that were built over 30 years ago have not been upgraded to accommodate the increasing population and the HIV epidemic which has placed increased burden on existing infrastructure.

With donor support, GRZ has placed Provincial Infrastructure officers in most provinces in order to spearhead and support infrastructure development in the health sector. Due to the fact that the position is not on GRZ payroll and the adhoc nature of funding for salaries, staff frequently resign from this position. At district level, GRZ relies on District Infrastructure Liaison officers (EHTS, planners) to spearhead and monitor works in the health sector. Most of the District Infrastructure Liaison officers have little or no professional skills and experience to comprehensively spearhead and support infrastructure development in the health sector. With that background, the ministry of works and supply provides additional support to the health sector though there is a limited number of staff in the districts.

In the six provinces supported by ZPCT, there are quite a number of donor projects supporting infrastructure development from which GRZ can leverage resources. The existing support in terms of infrastructure support comes from: SIDA, EU, Global fund, UNDP, DFID, USG though most of this support is usually compartmentalized and targets specific areas of support as per donor priorities/mandates. There is limited harmonization and collaboration of donor supported infrastructure projects with GRZ infrastructure plans.

*Proposed transition strategy, steps/phases/stages, and timeframe*

Due to the large need, refurbishing<sup>4</sup> facilities will remain an activity implemented under D-SERVE. However, D-SERVE can only partially fill the need. Most facilities were build 30 years ago and have not

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<sup>4</sup> For ZPCT, “refurbishments” means substantial improvements such as increasing or reorganizing space and substantial improvements to infrastructure, not just cosmetic improvements.

been upgraded since. The infrastructure budget for the MOH is focused on constructing new facilities, rather than upgrading the old, and there is little information on infrastructure readiness. The main strategy for transitioning refurbishment to GRZ will be to work with the GRZ to assess the needs, convince the national MOH of the importance of refurbishments, create a long term government plan for upgrading all facilities, and work with GRZ to fund this plan from GRZ and other funding sources. GRZ to begin budgeting for them, help them fundraise from other financing sources (donors and private sector).

*Help MOH establish refurbishment (infrastructure readiness) standards and strengthen GRZ infrastructure readiness assessment tools.*

*Support MOH to complete an infrastructure readiness assessment to quantify need (cost, services affected, number of beneficiaries affected).*

*Build support within key departments of MOH and MCDMCH to plan and budget for refurbishments.*

*Work with MOH to get this plan funded.*

Specifics of the transition

*GRZ roles and responsibilities for tasks/activities*

#### **Post D-SERVE transition vision**

Complete integration of donor funded refurbishment processes with government systems.

#### **GRZ roles and responsibilities for tasks/activities**

<b>Task done by ZPCT II</b>	<b>Who would do it post-transition?</b>
Identify and prioritize sites needing refurbishment	DCMO
Conduct health facility assessment	MOH PIO (provincial infrastructure officer)
Sketch drawings, create budget estimates, prepare implementation plan	MOH PIO
Recipient agreements (tender document)	MOH PIO
Review and award contracts	MOWS – district tender committee or provincial tender committee depending on value
Make 4 inspection visits	MOWS District works supervisor (Provincial Infrastructure Officer? Limited availability and willingness) (EHT may join, but are construction experts)

#### **Timing/milestones:**

<p><b>What could be achieved by the end of ZPCT IIB (Sep 2015):</b></p> <ul style="list-style-type: none"> <li>- Assessment of health facilities and compilation of refurbishment needs for inclusion in D-SERVE and MOH Health Infrastructure Operational Plan work-plans and budgets.</li> </ul>
<p><b>What could be achieved in the first year of D-SERVE (Sep 2016):</b></p> <ul style="list-style-type: none"> <li>- Production of tender documents, tendering and execution of targeted refurbishment works for 2016</li> <li>- Orientation of point person, preferably Provincial Infrastructure Officer, on donor funding requirements</li> </ul>
<p><b>What could be achieved by the mid-term of D-SERVE (Mar 2017):</b></p> <ul style="list-style-type: none"> <li>- Partial integration of donor funded refurbishment process with government</li> </ul>

**What could be achieved by the end of D-SERVE (Sep 2020):**

- Complete integration of donor funded refurbishment process with government systems

**Transition milestones and timelines**

- Joint assessment of health facilities and compilation of refurbishment needs for inclusion in D-SERVE and MOH Health Infrastructure Operational plans and budgets-Sep 2015.
- Joint production of tender documents, tendering and execution of targeted refurbishment works for 2016-Sep 2016.
- Orientation of point persons, preferably the Provincial Infrastructure Officers and DCMOs on donor funding requirements-Sep 2016.
- Partial integration of donor funded refurbishment process with GRZ-March 2017
- Complete integration of donor funded refurbishment process with GRZ systems-Sep 2020

*Capacity strengthening needs*

<b>Area for Capacity building</b>	<b>Capacity Strengthening Process</b>	<b>Timeframe and LOE expected</b>
Identification and prioritizing sites needing refurbishment including feasibility assessments and cost estimates	<ul style="list-style-type: none"> <li>- Orientation of MOH/MCDMCH technical staff by ZPCT IIB/D-SERVE technical staff to existing and new strategies/services and the corresponding space requirements.</li> <li>- Orientation of PIO to concept of 'refurbishment' as defined by USAID rules and regulations and its limitations with regards construction.</li> </ul>	First year of D-SERVE.
Improved patient flow, infection control and environmental compliance	<ul style="list-style-type: none"> <li>- Orientation of MOH/MCDMCH technical staff especially PIO to patient flow requirements as per established strategies and training in environmental friendly design and compliance as stipulated by USAID and ZEMA regulations.</li> </ul>	First year of D-SERVE.
Production of standard architectural drawings, producing BOQ's using SMM7.	<ul style="list-style-type: none"> <li>- Recruit qualified architects and quantity surveyors as PIO or liaise with Min of Works and Supply to ensure standardized tender document production.</li> </ul>	First year of D-SERVE or liaison with Min of Works throughout life of project.
Donor rules and regulations in review and award of contracts	<ul style="list-style-type: none"> <li>- Orient and train MOH/ MCDMCH staff in USAID rules, regulations and financial compliance.</li> </ul>	First year of D-SERVE.
Supervising, monitoring, inspecting and certifying works	<ul style="list-style-type: none"> <li>- Orient MOH/MCDMCH staff in USAID reporting requirements, document filing, before and after photographs etc.</li> </ul>	First year of D-SERVE.

#### *Procedural changes*

- Adopt the use of Firm fixed price contracts for new construction with fixed scope to promote efficiency.
- Hasten the process for variation contracts for any additional costs arising from unforeseen extra works (under refurbishments).
- Improve on confidentiality and follow government policy of non-disclosure of tender evaluation outcomes before contract award.

#### *Buy-in*

Ministry of Works and Supply staff sometimes hesitant to participate in the tendering process because of lack of allowances. Directive issued from high level would compel staff to be accept process.

#### *Outputs and outcomes*

Initially, the level of renovations done would be lower than those for the project but with time and support, GRZ is able to budget and carry out maintenance of infrastructure and renovations.

#### *Inputs*

In the transition, the project can work with the Provincial Infrastructure Officer though these are supported by various donors and come under the MOH. Funds can be leveraged from donors and eventually be in the action plans despite infrastructure funds sitting at MOH.

#### *Quality assurance*

There is need to ensure that the position of Provincial Infrastructure Officer and District Infrastructure Liaison officers (EHTS, planners) are filled with qualified staff.