



## Year 2 Annual Report (Oct 2005-Sept 2006)

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**Abbreviations/Acronyms**

AIDS	Acquired Immunodeficiency Syndrome
ADR/E	Adverse Drug Reaction/Event
BHCP	Basic Health Care Package
CARE	Cooperative for Assistance and Relief Everywhere
CCS	Clinical Care Specialist
CHN	Child Health and Nutrition
CHWk	Child Health Week
CIDRZ	Centre for Infectious Disease and Research in Zambia
COG	Clinical Officer General
CRS	Catholic Relief Services
CTC	Counselling Testing and Care
DHMT	District Health Management Team
EmOC	Emergency Obstetric Care
EPI	Expanded Programme of Immunization
FP	Family Planning
GNC	General Nursing Council
HBC	Home Based Care
HCP	Health Communication Partnership
HRDC	Human Resource Development Committee
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSSP	Health Services and Systems Programme
ICC	Interagency Coordinating Committee
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IRH	Integrated Reproductive Health
IRS	Indoor Residual Spraying
ITNs	Impregnated Treated Nets
LTFP	Long Term Family Planning
M&E	Monitoring and Evaluation
MCZ	Medical Council of Zambia
MDGs	Millennium Development Goals
MOH	Ministry of Health
MOU	Memorandum of Understanding
NGO	Non Governmental Organization
NITCS	National In-Service Training Coordination System
NTGs	National Training Guidelines
NMCC	National Malaria Control Centre
PA	Performance Assessment
PAC	Post Abortion Care
PHO	Provincial Health Office
PMTCT	Prevention of Mother to Child Transmission
PRA	Pharmaceutical Regulatory Authority
RED	Reach Every District
RH	Reproductive Health
RHIS	Routine Health Information System

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SWAp	Sector Wide Approach
TA	Technical Assistance
TB	Tuberculosis
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UTH	University Teaching Hospital
WHO	World Health Organization
ZDHS	Zambia Demographic Health Survey
ZPCT	Zambia Prevention Care and Treatment

## 1 Background

### 1.1 Overview of the Program Goals, Objectives, and Strategies

The Health Services and Systems Program (HSSP) is a key contributor to the Ministry of Health goal of improvement of the health status of Zambians. Specifically the HSSP's goals are twofold:

- Improved access to quality Reproductive Health (RH) and Child Health and Nutrition (CHN) services.
- Increased capacity of all levels of the health system and statutory bodies to achieve Human Resource and systems objectives for HIV/AIDS

The overall program objectives are:

- Achieve and maintain high coverage for key health interventions i.e. CHN, RH and HIV/AIDS
- Improve quality of the key health interventions
- Strengthen health systems for delivery of key health interventions

HSSP's approach is that of providing technical support enabling achievement of the given objectives. HSSP works at the national, provincial, and district levels to ensure that the district capacities are strengthened to provide the key health services. Geographical focus is driven by need, i.e. C and D districts for human resource, non implementing districts for Integrated Management of Childhood Illnesses (IMCI) and low performing districts in immunisation and Vitamin A supplementation. Other targeting criteria include level 1 and/or 2 hospitals and given health facilities for support in RH.

The general strategy has been to scale up already existing services and systems. HSSP is also consciously building sustainability and institutionalisation by working through established structures. Through this strategy, HSSP is able to integrate what has worked into the mainstream service delivery and related support systems. Applying the "systems approach" approach also helped HSSP ensure that it involves all relevant stakeholders at different levels, allowing for synergies and leveraging of resources.

## **1.2 HSSP Year 2 Operating Environment**

### **1.2.1 Ministry of Health Restructuring**

HSSP's operating environment during this year was challenging. During this period the Central Board of Health (CBoH) was officially disbanded and its personnel incorporated in the Ministry of Health (MoH). Since 1995 the CBOH had functioned as the "implementing arm" of the ministry whose major responsibility was the day-to-day management of service delivery programs. In this capacity the CBOH had recruited and utilized a broad range of technical and programme management specialists. Because the salaries and conditions of service of CBOH personnel were significantly better than those in the MOH, some CBOH employees chose not to join the MOH during and after the transition. An even bigger proportion was not motivated enough for continued work. This created a severe vacuum of key operational personnel and programme management capacity within the Ministry, which continues to this day. HSSP was asked, for example, to loan Dr. Reuben Mbeve to the ministry for a period of six months where he functioned as the senior reproductive health specialist in the Ministry. Many specialist and other technical positions have been empty or have been filled by relatively new and inexperienced personnel.

HSSP's role during this period has been to plug the holes and fill the gaps. HSSP technical staff has, in many ways, functioned as the institutional memory and a key driving force within the ministry during this period; they have stepped in to keep programmes and activities moving. Technical leadership in reproductive health, EPI, child health, nutrition, HIV/AIDS and maternal health has to a significant degree come from HSSP. The ministry's difficulty in motivating and retaining high level technical personnel has meant for example that the HSSP's HMIS personnel have played, and continue to play, a central role in maintaining the HMIS/ARTIS system.

### **1.2.2 Human Resource and funding Strategies**

Inadequate human resource at district level has continued to result in failure to implement all planned activities. This challenge affects all HSSP's work.

Funding to the districts has continued to be below budgets submitted. This has affected has limited the district's capacity to institutionalize and scale up some of some activities.

Appreciation of the Kwacha compounded with the lack of funds and was responsible for difficulties in implementing the planned activities. This affected all partners and leveraging resources was equally undermined. Some partners on whom some of the planned activities were dependant did not ultimately fulfill their initial pledges.

### **1.2.3 HSSP Restructuring**

Another major challenge to HSSP in the past year was precipitated by the dramatic appreciation of the Kwacha from 4500 to the dollar to 2900 to the dollar. Given that HSSP funding is relatively fixed, and that it comes in dollars, the programme was faced with approximately a forty percent decline in its financial resources. A significant amount of management time and energy had to be diverted to the analysis and decision making that led to the financial and programmatic restructuring of HSSP.

What started as a three month long effort to implement changes stretched into an ordeal of almost eight months. HSSP ended up losing 30 of its 79 person staff, half from the technical and half

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from the administrative side. Staff were informed of the impending changes in February, but for a variety of reasons, the formalities for retrenching could only be conducted by the end of July. This long period of doubt and uncertainty led to reduced morale and motivation, since no one knew who would go and who would stay. This situation also meant that staff could not be involved in the planning for the redesigned programme, placing an additional burden on all concerned.

Overall, the reduction in funding, diversion of management time, lowered staff morale, and the prolonged period before final resolution all combined to reduce HSSP's productivity and performance during this reporting period.

## **2 Child Health and Nutrition**

### **2.1 Overview**

Infant and under five mortality remain high in Zambia. The country has an under-five mortality rate of 168/1000. The neonatal mortality rate is 37/1000 live births (DHS 2001/2). 40% of the infant deaths occur during the first month of life and one in six children will die before their 5<sup>th</sup> birthday. The Bellagio Child Survival series of papers, published in *The Lancet* of 2003, classified Zambia as a “Profile Four” country, where malaria and AIDS are leading causes of under-five deaths, along with pneumonia, diarrhea, neonatal disorders, and malnutrition. Pediatric AIDS is now among the first ten causes of mortality in the under fives as evidenced by a study in children admitted to University Teaching Hospital (UTH) in Lusaka that showed an HIV sero-prevalence of 25 percent. Another modeling study of the contribution of HIV to under-five mortality, estimated that AIDS causes 21 percent of the mortality in this age group in Zambia.

The Ministry of health (MoH) and its cooperating partners has focused its efforts to improve child health and nutrition (CHN) through the implementation of such strategies like integrated management of childhood illness (IMCI), which was introduced in 1996, and Expanded program on immunization (EPI) and various nutritional programs like micronutrient supplementation and food fortification. All these are part of Zambia’s basic health care package (BHCP). They are relatively well-established but have critical weaknesses that limit coverage and quality.

### **2.2 General strategy and Core Activities**

The HSSP strategy has been to work with MoH/CBoH, PHOs and selected high risk DHMTs to strengthen the health systems for continuously ensuring provision of quality health services through high performing health workers in the discharge of their professional duties. HSSP investments aim to strengthen systems at national and sub-national levels to support increased coverage and integration of health services.

Investments are also being directed towards the developing and testing of sustainable approaches to scale up Child Health and Nutrition services. To this end, the team has focused on high-impact activities to improve coverage and quality of Child Health and Nutrition services as well as integrate and support related HIV/AIDS services.

HSSP’s support to Child Health and Nutrition in 2005/06 was in the areas of 1) supporting and sustaining the Expanded Programme of Immunization to increase the number of districts with at least 80% coverage, 2) increasing the number of districts that are implementing IMCI, 3) the development, testing and printing of IMCI training materials, 4) extending the provision of six key family practices (breastfeeding; immunizations; complimentary feeding; the combination of Vit A, deworming and growth monitoring; sleeping under an ITN; and home management and prompt referral ) to the community level through the work of CHWs and others, and 5) the introduction and testing of the Positive Deviance/Hearth approach to the prevention and treatment of malnutrition.

Activities used to achieve these objectives included: implementation of the RED (Reach Every District) strategy to improve the implementation of Child Health Week in poor performing districts; the provision of planning and technical support to assure that Vitamin A supplementation coverage is sustained and increasing in the districts; technical support to the NFNC to develop nutrition policies, guidelines, feeding practices, a NFNC strategic plan, an annual report on the nutrition status of Zambia, and a chapter on nutrition that is in the National Development Plan; attendance and support for key planning and technical meetings; technical assistance and problem solving leading to the approval and funding of the GAIN proposal; sponsorship and leadership of annual meetings of key personnel such as MCH coordinators and Provincial Health Directors; the provision of technical support supervision (TSS) at district level by HSSP central specialists and Clinical Care Specialists; very active participation in the work of central planning and monitoring bodies such as the UCI Secretariat and the NFNC; the provision of technical support and coordination for the development of the Global Fund Round Six proposal; monitoring of Child Health Week supplies and their distribution: the review of district action plans to assure that key health intervention are included and budgeted; the development of “technical updates” to guide district planning, the costing of the National Health Strategic Plan; collection, review, analysis and reporting of data; identification of and intervention in poor performing districts; and many other activities.

## 2.3 General Child health

### 2.3.1 Accomplishments

#### *Child Health Policy finalised*

During the second year of HSSP existence, support was provided to MOH to finalize the Child Health Policy. This work has been completed and the document has since been submitted to cabinet for approval. The child health policy will provide guidelines for the implementation of child health activities by various stakeholders.

## 2.4 Facility IMCI

### 2.4.1 Overall goals and Annual targets

**Goals:** The goals were to have 60% of health workers who manage sick children trained in F-IMCI; 72 districts implementing F-IMCI; and 60% of children presenting with common childhood illness managed according to IMCI guidelines.

**Year 2 targets:** The target were to train 200 health workers in year two; scale up to 50 districts implementing IMCI; and have 35% of children presenting with common childhood illness managed according to IMCI guidelines.

### 2.4.2 Accomplishments

#### *5 Districts Orientated in IMCI:*

The year under review commenced with the child health team providing TA to MOH/PHO in conducting comprehensive IMCI orientation to five districts. These were Mpongwe, Masaiti, Kapiri Mponshi and Mumbwa. This activity sets the stage for scaling up of district IMCI implementation. It also marked completion of the orientation process for all 72 districts and 9 PHOs.

District profiles developed:

In order to provide more focused TA, district profiling with regards to F-IMCI was undertaken to assess the number of IMCI trained health workers as well as staff trained at the DHMTs. A review of all the 72 district action plans was also undertaken that indicated planning and budgeting for F-IMCI was inadequate and most districts lacked the requisite IMCI targets. This information, coupled with the respective under-five mortality rates for the districts, was used to identify 10 priority districts for focused TA in year 2.

Districts identified for targeted F-IMCI support

- Mpongwe: No IMCI trained health workers and recently oriented
- Chama: High malaria area, very remote, highest district Under 5 Mortality
- Lundazi: High malaria area, high Under 5 Mortality, remote
- Chilubi: Very remote, very difficult referral system
- Kaputa: High Under 5 Mortality, very remote
- Senanga: High mortality rate
- Lukulu: Very remote, difficult referral system, recently oriented in IMCI
- Kalabo: High Under 5 Mortality, difficult referral system, recently oriented in IMCI
- Chingola: No IMCI trained health workers and recently oriented
- Chipata: category (unique case) B district with good numbers of IMCI trained health workers, but high Under 5 mortality rate.

Resource for Printing Mobilized:

Resource mobilization for bulk printing of F-IMCI training materials continued throughout the year mainly through the Interagency Coordinating Committee (ICC). A proposal was written, presented to and endorsed by the ICC. This resulted in some materials being printed with WHO and GTZ finances, and pledges from UNICEF.

151 Health Workers trained:

99 health workers were trained in IMCI case management. These included 18 PHO/ DHMT staff that were trained through the abridged 6 day course in order to build capacity at the respective levels. The 18 staff were strategically chosen from 15 PHO/DHMTs country wide that evidently had limited capacities to support IMCI implementation.

The 15 PHO/DHMTs that were represented in this training were, Lukulu, Lundazi, Mansa, Luwingu, Mpongwe, Chilubi, Kaputa, Mumbwa, Kapiri

Mposhi, Ndola, Lusaka, Livingstone, Mongu and Kasama.. The rest of the health workers trained in the 11 day case management were from Chipata, Lundazi and Kapiri Mposhi districts as well as the final year students from Chipata Nursing School. The total number trained is less than the targeted 200 mainly due to the drastic reduction of the district basket funding. Training activities are core funded with the district as a strategy for institutionalisation. In addition, 30 health workers underwent a refresher course in the HIV adapted IMCI algorithm and 22 facilitators were trained in a TOT for IMCI complimentary course.

12 More districts implementing IMCI:

In view of the district and provincial IMCI orientation process that has been completed and the trainings that were conducted by respective districts, 12 more districts have been added to the list of the IMCI implementing districts bringing the total to 54. This achievement is higher, by 4 districts, than the target set for the year.

2 Technical Support Supervision visits undertaken:

The Child Health Team supported two very successful Technical Support Supervision visits during the year. The first was to Northern Province –Chilubi and Luwingu and the second was to all the 8 districts of Eastern province. In both these activities, the response was very positive and efforts were made to build capacity focusing on given needs. The clinical care specialist for Northern Province had this to say after the visit: “Thank you very much for the support, the visit was very educative, I appreciate.”

Situation Analysis on New Born Health Conducted:

In addressing the new initiatives in child health, HSSP supported MOH to conduct a preliminary situational analysis on new born health in Zambia with technical support from SAVE the Children. The report has been finalized and disseminated to stakeholders to be used as a resource document in upcoming work. HSSP is now part of the core group tasked to develop a new-born-health position paper for Zambia.

District planning process supported:

Support was provided to the district planning process to ensure that F-IMCI was adequately planned for. Guidelines were provided to the various HSSP planning support teams on key issues to include for F-IMCI. It is expected that the 2007 district action plans will have more comprehensive activities than in the previous year.

\*Implementing the IMCI curriculum in training institutions:

The process of implementing the IMCI curriculum in training institutions has been a challenge. No consensus has yet been reached on the mode of training and the materials to be used. This delay has been due to financial constraints to call a meeting involving the key stake holders. The General Nursing Council needed to call a meeting with representatives from all training institutions. A three day process was envisaged, characterized by sharing experiences, reviewing different training modes used by training institutions, and agreeing on which one to adopt. A standardized way of examining for IMCI also needed to be developed during the same meeting. Unfortunately MoH and WHO did not plan for this activity and hence HSSP was left without a fall-back measure.

### 2.4.3 Key Results

- IMCI orientation and planning guidelines distributed to all the 72 districts
- All provincial and district offices oriented in IMCI strategy
- Bulk printing of IMCI training materials
- 81 health workers trained in IMCI case management
- Capacity to support IMCI implementation built in 18 DHMT staff through training in the 6 day IMCI abridged course
- 30 health workers trained in a refresher course in HIV adapted IMCI algorithm
- 22 facilitators trained in TOT for IMCI complimentary course in HIV

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- TSS conducted for Northern Province (Chilubi and Luwingu) districts and all the districts in Eastern province
- Capacity built for 8 DHMT staff (8 districts in Eastern Province) in conducting IMCI supervisory visits using the follow up after training tools (on the job approach)
- Lukulu district oriented in use of tools for follow-up after IMCI training
- IMCI implementing districts scaled up from 38 to 54 districts.

## 2.5 Community IMCI

### 2.5.1 Overall goal and Annual targets

**Goal:** 80% districts offering Key Family Practices  
**Year 2 Target:** 45 districts implementing Key 6 Family Practices

### 2.5.2 Accomplishments

#### 1,076 people trained in 6 Key Family Practices successfully conducted:

To date 6 provinces and 55 districts have been oriented to the concept and key family practices. These are currently training Community Health Workers who will promote the six Key Family Practices in the community that are vital for optimal child survival, growth and development. 190 trainers and 886 CHWs were trained to promote 6 Key Family Practices at community and household levels, in 55 districts and 6 provinces.

#### Successful leveraging of resources:

Churches Health Association of Zambia (CHAZ) has made a significant contribution to training of more Community health Workers in addition to the above. HSSP only provided the technical support to this process. Other partners have also supported MoH with resources for bulk printing of training materials to support the expansion of C- IMCI. HSSP's role has been to work with the MoH to identify organisations and advocate for such partnerships.

#### C-IMCI Strategic Plan disseminated:

The 2006 – 2009 C-IMCI strategic plan that will provide basis for resource mobilization, planning and monitoring implementation of C-IMCI in Zambia was printed and disseminated to all provinces and respective districts.

#### Printing and dissemination of Key Family Practices

Posters on the Key Family Practices were printed and disseminated for IEC in facilities and the community. Posters on the Key Family Practices were printed and disseminated for IEC in facilities and the community.

#### Hearth/Positive Deviance (H/PD) Initiated in Lukulu district:

The Positive Deviance Hearth approach, aimed at improving the health status of children, was successfully implemented in Lukulu district. H/PD is a participatory learning approach which brings together care givers with healthy and unhealthy children living in similar social economic conditions to share their practices. An initial group of 10 care givers was facilitated with HSSP support through Save the Children. The district has since taken over and added another 20 caregivers and children to the pilot project. Results will be used to scale up P/D Hearth to other districts.

### 2.5.3 Key Results

- Emerging leadership and ownership of community IMCI in the MOH
- 190 trainers and 886 CHWs trained in Key Family Practices- hence expanded district capacity to implement C-IMCI.
- Increasing partner involvement in C-IMCI e.g., CHAZ participation
- 2006 – 2009 C-IMCI strategic plan printed and disseminated
- C-IMCI Key Family Practices posters printed and disseminated
- Leveraged resources to bulk print Community Health Worker C- IMCI training materials
- Successfully implemented the Positive Deviance Hearth approach in Lukulu district

## 2.6 Expanded Programme on Immunization (EPI)

Zambia recognizes the importance of improving and sustaining high immunization coverage rates, and quality surveillance throughout the country. In view of the polio free certification status attained with HSSP support, it has become even more critical to strengthen and sustain surveillance activities in all the districts.

### 2.6.1 Overall Goal and annual targets

**Goal:** 80% full immunisation coverage of children under one year in 80% (58) districts.

**Year 2 Target:** 80% full immunisation coverage in children under one in 43 districts

### 2.6.2 Accomplishments

#### 36 districts attain at least 80% full immunisation coverage:

The number of districts with full immunization coverage of 80% and above for children under one year increased from 33 in fourth quarter 2004 to 37 in first quarter 2005 and 36 districts in 2<sup>nd</sup> quarter 2006. MoH will be supported to sustain and scale up these achievements. Further, 15 poor performing districts were identified from the 2005 immunization coverage levels for more targeted technical assistance.

#### Zambia awarded US \$ 3.6 million for going above the targeted immunisation coverage:

Zambia's immunization performance was again awarded \$3.6 million for extra children immunized above the target. It is hoped that the extra resources will be used to expand RED strategy and other child health interventions to 72 districts. HSSP will continue to provide support to this cause and assist in re-programming the extra resources more effectively.

#### RED strategy expanded to 36 districts:

The Reach Every District (RED) strategy initially piloted in 10 ten districts, has been expanded to 36 districts with endeavors to integrate other child survival interventions. Documentation of innovations on the RED strategy and Primary Health Care (PHC) initiative in Luangwa district has been undertaken.

#### EPI Multiyear plan disseminated to all districts:

EPI/Multi year plan disseminated to all districts where critical points in planning and monitoring implementation of comprehensive EPI were emphasized.

#### 3<sup>rd</sup> round of Maternal Neonatal Tetanus Elimination campaign succeeds:

The 3<sup>rd</sup> round of Maternal Neonatal Tetanus Elimination campaign was successfully implemented. This resulted in high coverage of TT2+ among women of child bearing age in Zambia. Validation of the current Neonatal Tetanus situation will follow using an external validation team.

#### Zambian government purchases vaccines:

Government contribution to purchase of traditional vaccines increased from 4% in 2002 to 78% in 2005 and 100% in 2006. This shows ownership of the immunisation program and recognition by the government of the responsibility to provide vaccines to its populace.

### 2.6.3 Key Results

- 37 attained immunization coverage of 80% and above for children under one in first quarter 2005, and 36 districts in 2nd quarter 2006 in fourth quarter 2004, as opposed to 33 districts in 2004.
- RED strategy expanded from 10 districts to 36.
- EPI/Multi year plan disseminated to all districts.
- Government contribution to purchase of traditional vaccines increased from 4% in 2002 to 78% in 2005 and 100% in 2006.
- ICC and UCI secretariat supported on timely reporting, data analysis and reporting required for response by the MOH child health team.
- Zambia's immunization performance re- Awarded a total of \$3.6 million for extra children immunized above target.
- Successful implementation of the 3rd round of Maternal Neonatal Tetanus Elimination campaign

## 2.7 Nutrition

The nutrition component focused on strengthening the micronutrients control programmes, general nutrition, and Infant and Young Child Feeding. The focus regarding micronutrients was on supplementation, de-worming and fortification. The strategy here was to address the problems of low coverage of vitamin A supplementation; providing support to development of the GAIN proposal for initiating maize fortification in Zambia and strengthen fortification monitoring.

In general nutrition, support to government continued to focus on further development of the nutrition chapter of the National Development Plan; food and nutrition monitoring and evaluation framework and the minimum package of care for nutrition in the health sector. Substantial input was also provided in Infant and Young Child Feeding- completing the draft operational strategy.

## 2.8 Vitamin A Supplementation and De-worming

### 2.8.1 Overall Goals and annual targets

**Goals:** Attain 80% national coverage of Vitamin A supplementation of children aged 6 – 59 months; and lactating women within 8 weeks postnatal;  
Attain 80% national coverage of de-worming children aged 12 – 59 months of 70%  
**Year 2 Targets:** Increase Vitamin A supplementation in children 6 – 59 months by 4 % and 10% in postnatal  
De-worming national coverage of children aged 12 – 59 months from by 5% (65%-70%)

### 2.8.2 Accomplishments

#### 72 District Action Plans reviewed:

All district action plans were reviewed to establish whether Child Health Week (CHWk) was planned for to cater for Vitamin A supplementation in children and postnatal women, and de-worming in under fives. Identified gaps were addressed through the strengthening of the 2007 national technical update for planning, and ensuring that the checklist for review of district action plans also addressed the need to plan for the various components of Vitamin A supplementation program.

#### Supplies and logistics management for CHWk strengthened:

A review meeting was facilitated for the central level stakeholders to discuss feedback received from provincial and district reports regarding supplies and logistics for implementing and monitoring of CHWk. Information generated has been utilized in revising the Child Health Week orientation manual.

#### District technical and administrative updates developed:

District updates were developed to provide information on key issues requiring their attention during implementation of CHWk i.e., technical and administrative information. Among the key issues were data management and organization at service delivery points. The information was also incorporated in the CHWk orientation manuals.

Eastern and Southern PHOs initiate CHWk review:

TA was provided to Eastern and Southern provinces PHO to facilitate a half day review meeting of Child Health Week. This was an innovation as the arrangements were made by PHO and they just requested for support from the centre. This success can be linked to the continued advocacy at various forums for ownership of the program at the provincial and lower levels.

CHWk Supervisory Tool Kit updated:

The CHWk supervisory Tool Kit was updated and subsequently distributed to the provincial offices for their use. This kit ensures that the core areas requiring supervision are covered and the quality of service delivery is monitored.

Support provided to poor and best performing districts:

Support to poor and best performing districts to improve and maintain high coverage respectively, was provided through working with PHOs and selected DHMTs before, and during CHWk implementation. The supportive visits before CHWk provided opportunities to discuss issues that needed particular attention in given districts.

Postnatal vitamin A supplementation incorporated into CHWk:

Consultations on the prospects of integrating postnatal supplementation into the Reach Every District (RED) strategy were explored during the quarter mainly through the supportive visits to Northern, Lusaka, and Central provinces and at other stakeholder meetings. Postnatal supplementation has now been incorporated as a service provided to eligible women during Child health Week.

### 2.8.3 Key Results

- All PHOs are currently supporting districts in planning and implementing CHWk. More PHOs are following up of district CHWk reports than before.
- Sustained utilization of the district basket funding for the implementation of Child Health Week.
- The results received from the June 2006 CHWk indicate improved coverage of Vitamin A supplementation of 81% compared to December 2005 round of 66%. Several factors that facilitated this include the supportive visits prior to CHWk and the continued support from both central and provincial level.

## 2.9 Fortification

### 2.9.1 Overall Goals and Year 2 Targets

**Goals:** 90% of the household sugar is adequately fortified with Vitamin A; 60% of the commercially produced maize meal fortified with a multi mix by the end of 2010.

**Year 2 Targets:** Improve the proportion of household sugar adequately fortified with Vitamin A from 18% to 25%; 20% of the commercially produced maize meal fortified with a multi mix.

## 2.9.2 Accomplishments

### GAIN proposal developed and approved:

Activities were centered on supporting the rigorous process of development of the GAIN proposal and work plan for the maize meal fortification project. The GAIN project was finally approved and the grant agreement signed on 27<sup>th</sup> February 2006. This has culminated into the establishment of the Maize Meal Fortification Project (MMFP) based at the NFNC.

### Maize meal fortification project established:

The US\$ 2.4 Million MMFP has a three year life span. Key activities completed so far under this project include:

- Recruiting all the staff needed.
- Holding advocacy meetings for Millers (Lusaka, Copperbelt and Luapula), all provincial and Ministerial Permanent Secretaries, Some members of parliament, Churches and NGO's.
- Processing procurements for the required equipment for Millers.
- Training manuals for millers on the fortification process have been drafted.
- A Statutory Instrument for maize fortification has been developed. The instrument is aimed at making fortification of commercially produced maize meal mandatory. This is expected to contribute to the reduction in the prevalence of Vitamin A, B2, B6, B12 and Iron deficiencies in the general population. The document has been submitted to cabinet for approval. The instrument will compel all commercial millers to fortify their maize meal.

### Assessment of Sugar Fortification conducted:

Through ISTI, two consultants were engaged to assess the fortification process at Kafue Sugar and Zambia Sugar to establish feasibility of the technologies used and quality. Their main conclusion was that better technology needed to be employed at both factories to ensure quality and cost effectiveness.

### Feasibility study for fortification of other foods conducted:

The feasibility study on the fortification of cooking oil and milk was conducted. The aim was to identify alternative food vehicles to reach as many people with fortified foods as possible. The report revealed that the process of fortification for the above food items would be very complicated and has serious implications on the significant population of emergent producers, who may not have the capacity to fortify their products.

## 2.10 General Nutrition

Support was provided to NFNC and MOH to strengthen nutrition interventions. The key activities that HSSP contributed to included the following:

### 2.10.1 Overall Goals and Year 2 Targets

**Goals:** All districts implementing the minimum package of care for nutrition by the year 2010; Sectors increasing nutrition interventions in their plans.

**Year 2 Targets:** Increase the number of districts and hospitals implementing the minimum package of care for nutrition

### 2.10.2 Accomplishments

#### *A Food and Nutrition monitoring and evaluation framework developed:*

This framework aims at integrating the various nutrition data sources in Health, Education and Agriculture on key interventions in nutrition in order to make information available for decision-making. The first food and nutrition situation annual report has been developed out of this effort. NFNC staff has also been oriented on this framework and various tools to ensure continuity of the activity. NFNC will manage the data base hence forth. Technical assistance from ISTI was sought to finalise the development of this framework.

#### *Nutrition Chapter in the National Development Plan 2006 -2011 developed:*

HSSP through the ISTI-supported consultants facilitated development of a nutrition chapter in the National Development Plan. This chapter has since been finalised and submitted for incorporation.

#### *Infant and Young Child Feeding (IYCF) operational strategy completed:*

In support of the Infant and Young Child Feeding program, support was provided to government towards finalization of the IYCF operational strategy for 2006 -2011. This plan aims at providing a framework for partners to buy into and implement interventions related to IYCF. It is hoped that the plan will enhance utilization of limited resources available for Infant and Young Child Feeding. In addition, HSSP contributed significantly to the development of IYCF guidelines. These will provide guidance to service providers and programmes focussing on infant and young child feeding. Further, HSSP participated in the orientation of National Assessors in the Baby Friendly Hospital Initiative. This is a strategy for transforming health care practices to promote optimal Infant and Young Child feeding practices.

#### *The code on the Marketing of breast milk substitutes finalised:*

The code is aimed at addressing the need to regulate the marketing practices of manufacturers and traders to protect mothers and infants from undue pressure. HSSP further facilitated the training of national level staff in the code of marketing of Breast milk substitutes.

Participation in World Breastfeeding Week:

HSSP participated in the preparations and commemoration of World Breastfeeding Week scheduled for 1<sup>st</sup> to 7<sup>th</sup> August 2006. The aim of the week is to create awareness on the need to promote breastfeeding; and to address the needs of infants born to HIV positive women.

A minimum package of care for nutrition developed:

In response to the recognition of the inadequate capacities in districts to plan for nutrition, a draft guide for planning and implementing nutrition programmes was developed.

Feasibility of Food Based strategy assessed:

A feasibility of implementing food based strategies to improve micronutrient malnutrition was conducted in the context of assessing programmes related to yellow fleshed potatoes.

### **3 Integrated Reproductive Health (IRH)**

#### **3.1 Overview**

At 750 per 100,000 live births, the maternal mortality ratio in Zambia is unacceptably high. The lifetime risk of maternal death is estimated at 1 in 19. More than half of deliveries currently take place outside of healthcare facilities and emergency transportation in cases of complications is limited. Almost all pregnant women receive some kind of antenatal care (ANC) and this represents a tremendous opportunity to reach women of reproductive age. Nevertheless, many women use these services late in their pregnancy and the services do not consistently include key interventions such as iron/folate supplementation, IPT to prevent malaria in pregnancy (MIP), and provision of antiretroviral therapy to prevent mother-to-child transmission (PMTCT). It is estimated that 13% of deaths are due to unsafe abortion. Delayed treatment is the major reason for deaths. Unsafe abortions are attributed to the unmet need for family planning services in Zambia (Source: DHS 2001/02).

HIV/AIDS has added a further threat to maternal survival and burdens a health system already unable to provide widespread access to quality essential and emergency obstetric care.

Importantly, Zambia's cadre of nurse midwives has been among the most affected by attrition over the past 5 years, draining not only service providers but qualified teachers and trainers for pre- and in-service training of skilled birth attendants. Even the deliveries that do occur in rural health clinics and hospitals are often attended by unskilled personnel. Current availability of midwives in Zambia is approximately 1 per 6,000 pregnant women – compared with international standards suggesting that one midwife could reasonably attend 250-300 births per year.

At 5.9 births per woman of reproductive age, total fertility rates remain high in Zambia. Currently, up to 23 percent of married women use some form of modern FP; 17 percent of women use modern methods. Despite the recent increase in modern FP use, condom use has not increased in recent years and 27 percent of married women still report an unmet need for modern FP. This is partly due to the unavailability of a wide range of methods of FP and the need to better integrate HIV/AIDS into contraceptive counseling and to integrate FP into antenatal/ postnatal, HIV/AIDS and other programs. There is also a continuing need to address adolescent reproductive health needs, and strengthen youth-friendly services. Oral contraceptives (OCs), including Microgynon and the socially marketed Safe Plan, are the most frequently used method of FP, and while Noristerat is available widely, DMPA has only been available in limited geographic areas. Norplant and vasectomies are minimally used and counseling in dual protection needs to increase. In addition, a large discrepancy exists between urban and rural modern contraceptive use, with 39 percent of urban married women using modern FP, a percentage three times higher than that of women in rural areas.

### 3.2 General Strategy

The IRH team worked closely with the CBoH to implement selected interventions that address the above challenges. Specifically HSSP focussed on scaling up PAC services, and overall updating provider knowledge, skills, and decision-making related to obstetric emergencies, including PAC; increasing access for maternal and newborn complications at sites closer to or within communities; and strengthening community birth preparedness and complication readiness through partnerships with TBAs, and other community based agents, and scaling up use of long term contraceptive methods. Sexually Transmitted Infections (STIs) will be integrated in reproductive health.

Human resource is still a great challenge. There is a general lack of mid wives which make it difficult to effectively implement activities. The referral system is to a great extent none functional. This poses a great challenge on successful implementation of PAC and EmOC.

### 3.3 Post Abortion Care (PAC)

HSSP focused on revitalizing the PAC Task Force as the basic planning, coordination, and technical assistance mechanism to manage the PAC scale up; strengthening and expand PAC training sites, including trainers, curriculum materials, supplies, and equipment to train the expanding numbers of PAC providers Establishing HMIS data collection and analysis procedures so as to acquire management and evaluation information in the identified sites.

#### 3.3.1 Overall Goals and Year 2 Targets

**Goal:** 100 % of Districts Offering PAC Services  
**Target:** 20 districts providing PAC Services (16 new in Year 2)

#### 3.3.2 Accomplishments

2 PAC Training Sites established:

Institutional assessments and follow-up visits were carried out at UTH and Ndola Hospitals to establish the readiness of these facilities to carry out extensive PAC training programmes which will occur intensively in Year 3.

14 Master Trainers Trained; PAC Training Curricula Developed and Tested:

HSSP's PAC specialist led an effort to revise and adapt the PAC training curricula for use in Zambia. 14 Clinicians were trained as Master Trainers, and the subsequently were used to train personnel for the districts.

PAC services scaled up to 6 districts:

PAC services were scaled up to from 4 to 6 districts in year 2. Accumulatively, 10 districts under HSSP have now been trained in the provision of quality PAC services.

12 Districts assesses for readiness for PAC:

There are 12 districts already assessed for PAC readiness inY2. These await PAC training in year 3.

PAC equipment and materials secured:

Adequate MVA sets for training and old stock replenishment were secured through partners and meetings were held to revitalize the National PAC task force. Therefore scaling up of PAC services will be much accelerated in year 3.

### 3.4 Emergency Obstetric Care (EMOC)

The second year of the project focused on assessing and strengthening 3 sites for EMOC training i.e., Livingstone, Lusaka, and Ndola; and identifying and training a master training team. These activities are a follow up to the EMOC needs assessments conducted earlier.

#### 3.4.1 Overall Goals and Year 2 Targets

<p><b>Goal:</b> 100 % of Districts Offering EmOC services <b>Target:</b> Establishing 3 training sites and training teams</p>
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#### 3.4.2 Accomplishments

EmOC assessment report finalised and disseminated:

The EmOC assessment report was finalized and disseminated meeting for provinces, districts and other stakeholders.

Successful advocacy to transform the UTH and Ndola hospitals into EmOC training centers:

Advocacy to transform the UTH and Ndola central hospitals into EmOC centers was successful. These hospitals were strengthened through donations of emergency surgical and labor ward equipment. 5 candidate trainers from each hospital were also identified.

Maternal Death Reviews disseminated in 4 districts:

Financial and technical support was also provided to southern province in the dissemination and scale up of the MDR initiative in 4 districts.

### 3.5 Focused Antenatal Care (FANC)

Year 2 core activities included orienting health providers to FANC through the maternal counseling Kit (MCK).

#### 3.5.1 Overall Goals and Year 2 Targets

<p><b>Goal:</b> 50 % of Districts Offering Focused Antenatal Care <b>Target:</b> 148 health facilities providing FANC</p>
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#### 3.5.2 Accomplishments

Safe motherhood guidelines developed:

Development of safe motherhood guidelines was finalized and the guidelines and printed.

MCH coordinators oriented to the MCK:

The MCH coordinators were oriented to the MCK. FANC has since been dropped in the restructured program.

### 3.6 Family Planning

HSSP's 5 year goal is to increase the CPR to 40 % through training, technical support and improved access to an expanded range of contraceptive methods in government clinics. The year 2 target was to have 18 districts trained in long term methods (Jadelle and IUD) and to establish mobile FP services. HSSP planned to use a cascade model to train FP providers at health facility level. Other major activities included strengthening provincial training sites; identifying provinces and districts that will begin to offer Long-term FP methods and assess readiness to provide these services; strengthen HMIS data collection and analysis so as to acquire management and evaluation information.

HSSP's financial crisis led to a slowdown in FP training activities, and the restructuring led to the loss of our Family Planning staff person during the year. Because of these problems no work was done towards the establishment of mobile FP services and this objective was dropped as an objective of the restructured project.

Despite these difficulties, the following results were achieved:

#### 3.6.1 Overall Goals and Year 2 Target

**Goal:** To increase contraceptive prevalence rate (CPR) to 40%

**Year 2 Target:** 18 districts trained in long term methods and mobile FP services established

#### 3.6.2 Accomplishments

National Family Planning Guidelines developed:

National guidelines for Family planning were finalized and copies printed.

Training manual developed:

A knowledge update training manual was also developed.

8 eight master trainers trained in LFP methods two master training sites established:

To get district level providers trained in long term methods a “cascade” model was utilized whereby a training manual was developed, eight Master Trainers were trained, two training master training sites were developed (Ndola Central Hospital and UTH), four (in some cases five) Provincial level trainers were trained in each of the nine provinces, and support was provided to have the provincial trainers in turn train district level staff. Supportive activities included provincial and district level site assessments, planning meetings with district management, and efforts to HMIS data collection.

5 Long Tern Family Planning sites (LTFP) established:

Five provincial training sites for LTFP methods were established following the master training. The provision of LTFP methods scaled up to 4 districts in southern province. The target of introducing FP services in 18 districts was not met. This is because more time was required for the preliminary activities than anticipated and partly due to funding constraints discussed earlier.

### 3.6.3 Key Results

- MCH coordinators from all 72 districts received a one week training programme including FANC, long-term FP methods, PMTCT, Malaria, supervision and logistics
- TA was provided to a national-level PMTCT taskforce to develop a workplan that included FP services to clients
- A comprehensive review was done of all components, including FP/RH, of 72 district action plans
- LTFP training site development (started in year 1) was continued with training, TA, and provision of a variety of equipment including pelvic models
- 44 Provincial level trainers (at least 4 and sometimes 5 per province) were trained for 10 days each at the 2 training sites
- Follow up visits were made to trained participants in all nine provinces
- A check in July 2005 showed that 2500 units of Jadelle, which were supplied by UNFPA, had been disbursed. 1269 clients had received the method from HSSP-trained workers in thirteen service delivery sites
- HSSP helped the Reproductive Health Unit develop a new IRH supervisory tool
- The National Family Planning Guidelines were finalized and printed
- A family planning update manual was developed
- Five provincial training sites for LTFP methods were established

### 3.7 Sexually Transmitted Infections

The five year goal is to integrate STI diagnosis and treatment into all RH services.

The year 2 target was to have treatment protocols, training materials, and training sites ready to deliver STI training. HSSP planned to develop training materials and support standardization of STI protocols; Train health workers providing reproductive health services in STI diagnosis and management using the syndromic approach.

HSSP's STI management activities were another casualty of the financial problems and the project restructuring. The STI staff member remained with the project for only five months of the reporting year. All work on STIs was terminated upon his departure and no further STI work will be done under the newly restructured programme. Nevertheless, the following was achieved during the reporting period:

#### 3.7.1 Overall Goals and Year 2 Target

**Goal:** Integrate STI diagnosis and treatment in all RH services

**Target:** To have protocols training materials and sites ready to deliver STI training

#### 3.7.2 Accomplishments

##### Consensus reached on STI training package:

A consensus meeting/workshop was held to review available STI training packages from WHO, JHPIEGO and GATES. The JHPIEGO set of materials was selected for adaptation and use in Zambia. Decisions were taken on course structure, duration, and target audience. Unfortunately, because of the departure of our staff member, no training was carried out.

##### 6 districts assessed for readiness to provide STI services:

Assessment visits were made to Solwezi, Ndola, Kabwe, Mansa, Kasama and Livingstone to prepare provincial hospitals for use as STI training sites. Only Solwezi and Kasama had someone trained in STI management. None of the hospitals had a clinic dedicated to STI treatment.

##### Assessment of male circumcision services conducted:

An assessment of male circumcision services was carried out at Ndola Central. Unfortunately these findings cannot be utilized further in the project as the component has been dropped.

### 3.8 Adolescent and Reproductive health

In order to improve access to youth friendly services, HSSP worked with the MoH and other stakeholders to train health workers; strengthen service delivery systems; and establish an effective monitoring system.

#### 3.8.1 Overall Goals and Year 2 Target

**Goal:** 576 health facilities providing youth friendly services  
**Year 2 Target:** 80 sites in 10 districts providing youth friendly health services

#### 3.8.2 Accomplishments

YFHS orientation package adapted:

A Youth Friendly Health Services (YFHS) orientation package for healthcare providers was adapted.

Data collection and management tools were developed.

53 sites assessed; 44 health providers trained:

53 sites were assessed for readiness to provide YFHS. 44 health providers were trained in southern province in conjunction with the Center for Disease Control (CDC).

## 4 Malaria

HSSP's work in Malaria prevention and treatment underwent a dramatic change during this reporting year due to different priorities emanating from Washington D. C. A new mandate resulting from the Kill Malaria Mosquitoes Now initiative required that 50 % of available malaria funding goes to the purchase of commodities for In-door Residual Spraying (IRS). HSSP was asked by the mission to take on new responsibilities for IRS program implementation. This implies a dramatic scale back of the malaria activities that have been supported up to now. The altered funding and program priorities mean that HSSP lost approximately \$1.4 million in “old” malaria funding, but was given approximately \$ 2 million to support new work on the Indoor Residual Spraying Programme. Planning and negotiations were carried out with the Mission and the National Malaria Control Centre. It was agreed the HSSP would build implementation capacity within the existing NMCC IRS Programme framework and that the NMCC would carry independent implementation and service delivery responsibilities for IRS as it has done in the past.

This Year 2 Annual Report on malaria activities is therefore divided into the “before” and the “after” program revision activities.

### 4.1 Support to NMCC (the “old” component)

HSSP's malaria support activities under the “before” scenario consisted of 1) management support to the NMCC, 2) support to the malaria intervention in child health; and 3) support for the malaria prevention and treatment interventions in reproductive health. Programme resources to support this set of activities was approximately \$ 2 million at the beginning of the year. Because of the shift of funding to IRS, the HSSP Programme will have only about \$300,000 to carry forward this work in future years.

Malaria in pregnancy (MIP) places both mother and child at significant risk of severe illness and death, especially in the presence of HIV. Four interventions to reduce MIP are: 1) Intermittent Preventive Treatment (IPT) with SP; 2) use of ITNs, 3) anemia reduction through the above plus micronutrients and improved nutrition, and 4) clinical management of pregnant women with malaria. HSSP supported the delivery of these interventions through focused antenatal care (FANC) for IPT and ITNs, through training of RH personnel in the malaria aspects of reproductive health, through work and budget planning with the RH Unit of the MOH and the NMCC, through advocacy, and through outreach to HIV/AIDS programs that can and should do more to prevent and treat Malaria in HIV-infected individuals. HSSP has been asked to support the goal of the MIP strategic plan which is, “At least 90% of women have access to the packet of intervention to reduce the burden of malaria in pregnancy, i.e. full-three course IPT, and ITN, anemia reduction and appropriate care for an acute malaria illness.”

Specifically, HSSP's support to malaria intervention for reproductive health during the reporting period fell into three categories: improvement of facility-based health worker performance through FANC and case management; community-based activities (Safe Motherhood and ARH interventions); and “systems support” activities that are described below.

HSSP also supported, and to a much more limited extent will now (after the funding change) support malaria interventions in child health. Malaria is the biggest cause of illness and death

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among under five children in Zambia, accounting for 45% of outpatient consultations and admission and an estimated 50,000 deaths per year. Moreover, malaria exerts a tremendous burden on the health care system, on education, and on keeping families in poverty.

HSSP plays a central role in maintaining and increasing coverage of malaria interventions in child health. The programme supports the Child Health Unit of the MOH with planning, budgeting and supervision; our child health staff and the province-based clinical care specialists support the provinces and districts with planning and program implementation support (ITP, ITNs, case management training and supervision, data analysis, strengthening referral systems); and HSSP's Malaria Advisor, logistician, and financial manager supported the central level NMCC with planning, research, computer support and administrative services.

HSSP assistance to malaria prevention and treatment in child health is delivered also through the Integrated Management of Childhood Illness (IMCI) programme. Childhood malaria is addressed through IMCI training which includes the diagnosis of febrile illness, treatment of malaria cases with SP and Coartem, caretaker counseling, and referral of complicated cases to the next level. A second, and less well known, aspect of IMCI is system strengthening which consists of: increased Technical Support Supervision (TSS) to districts and health centers by district-level supervisors and Clinical Care Specialists; review and support of district planning from the child health/IMCI perspective; training; policy and guideline development; and information management. A third element of IMCI is community interventions which include the training and supervision of CHWs, support to Child Health Week, IEC activities through the Malaria IEC Theme Group, and the financial support of the Zambia Malaria Foundation that supports NGO and CBO malaria work throughout the country.

HSSP's third broad area of support to malaria (in addition to Malaria-in Reproductive Health, and Malaria-in Child Health) is in the provision of scientific, technical, managerial, and administrative support to the central level National Malaria Control Centre. USAID has provided this type of assistance to the NMCC since 1998 first through the ARCH project of Boston University and since 2004 through HSSP. The HSSP Programme in this past reporting year provided assistance in three ways. First, three HSSP personnel worked directly with the NMCC: a Malaria Programme Officer (providing support for logistics, computer system operations and capital improvements); a newly recruited Senior Finance and Administrative Officer, and a Senior Resident Advisor (who left in July 2006). Second, HSSP provided salary support for the NMCC Accounts Officer, Operations Research Officer and a number of support staff. Third, HSSP provided \$1,100 per month in support for the NMCC's internet connection.

### 4.1.1 Overall Goals and Year 2 Target

**Goal:** HSSP's goal has been to support the MOH's goal of "a 75% reduction in malaria incidence and a 20% reduction of all cause mortality by the year 2011".

### 4.1.2 Accomplishments

#### Maternal Counseling Kit (MCK) finalised and printed:

The Maternal Counseling Kit (MCK) finalised and printed for use in health facilities. The kit contains counseling for MIP, ITP, ITNs, and malaria in childhood.

72 MCH coordinators trained in use of the MCK:

The coordinators were drawn from all DHMTs. They are in turn expected to train facility staff on how to use the kit.

District planning guidelines for Malaria for the 2006/7 planning cycle developed:

Similar guidelines developed for the Medium Term Expenditure Framework (MTEF)

#### 4.1.3 Key Results

- 72 MCH coordinators trained on how to use the MCK
- The placement of a program/logistics and a financial management officer at the NMCC
- Lectures in Medical Entomology and Malaria delivered to Microbiology and Medical Students
- Computer systems and internet connection support delivered to the NMCC
- Maintenance and support to the planning and implementation of malaria services through the Senior Resident Advisor
- Development and use of district planning guidelines for Malaria for the 2006/7 planning cycle
- Similar guidelines developed for the Medium Term Expenditure Framework (MTEF)
- Review of 72 district action plans (2005/6) to identify strengths and weaknesses of malaria programming
- Support to the NGO and CBO work of the Zambia Malaria Foundation
- Survey of ARV, Malaria and TB drugs in 7 provinces, 11 districts and 25 health centers completed
- Incorporation of MIP materials into FANC and PMTCT training materials
- Provision of technical support and coordination for the development of the Global Fund Round Six proposal for Malaria
- Technical support provided to the ITN Working Group for the development of ITN Guidelines which are being printed by UNICEF
- Training of ten trainers and deployment of Rapid Diagnostic Tests to 68 Provinces (Note: there are continuing problems with the use of RDTs)
- Production of a “Final Report” of the departing Senior Malaria advisor with a comprehensive review of past progress, present activities, and recommendations for future priorities for the overall Malaria Programme in Zambia

## 4.2 In-Door Residual Spraying – IRS (New Component)

As noted in the introductory paragraphs of this section, HSSP's malaria funding has changed during the 2005/06 reporting year. Much of the work described above will be dramatically scaled back because the programme will have only around \$300,000 to support these activities. Approximately \$ 2 million in new Malaria monies will now be channeled towards support of the NMCC's Indoor Residual Spray Programme.

**Goal:** The IRS Programme goal for the upcoming 2006/7 spray season is to spray 700,000 households in fifteen target districts.

### 4.2.1 Key Results

- Development, in collaboration with the NMCC, of a comprehensive plan and budget for HSSP technical assistance and support that will go to the IRS programme
- Quantification of the amount of insecticide, equipment, personal protective equipment and number of spray men and supervisors what will be required in the upcoming spray season
- Preliminary planning, writing of job descriptions, and setting up of interviews for the placement of four staff to support the IRS Programme: a Senior Resident Advisor; an IRS Logistics Officer; an Information and Applied Research Officer, and a Senior Spray Operations Manager
- Planning and preparation for the training of spray men in the 15 target districts.
- Development of plans for monitoring, supervision, and environmental safeguards for the upcoming spray season
- Assessment of, and planning for the storage facilities and storekeepers for the upcoming delivery of insecticide and equipment
- Planning for and solicitation of bids for the Personal Protective Equipment (PPEs)

## 5 HIV/AIDS Coordination, Human Resource and Systems Support

### 5.1 Overview

This component covers HIV/AIDS Coordination, Human Resource for Health and Health, and Systems Strengthening work. The goal here is to have all districts with at least one facility offering a minimum package of HIV/AIDS services by 2010. The package was generally defined as having ART, CTC, PMTCT, HBC and some defined laboratory services. The specific technical areas in this component include HIV/AIDS Coordination, Human Resource Planning and Management, Pre and In-service Training, Health Services Planning, Policy, Health Management Information System, ARV Drugs, and Health Care Financing. The targets for 2005/2006 were to have 28% of districts with at least one facility offering a minimum package of HIV/AIDS services; 40% of district health worker training programmes using standardized national training programmes; and 2% of health facilities providing HIV/AIDS services according to minimum standards.

### 5.2 Human Resource for Health (HRH)

HSSP's focus for 2005/2006 was to ensure that 28% of districts were planning for HR requirements to deliver a minimum package of HIV/AIDS services. HSSP employed a combination of short and long term HR management and development strategies in order to accomplish the set targets. These focused on strengthening the national system for HR planning and management; Target 20 districts for support in retaining staff with critical skills to deliver a minimum package of HIV/AIDS services; Strengthen training institutions' capacity to train critical cadre to provide HIV/AIDS services; strengthen MoH's capacity to establish a national in-service training coordination system information management system; develop a mechanism for accreditation of ART sites/providers ensuring adherence to national treatment protocols.

HSSP activities for 2005/2006 were also built on the accomplishments of year one activities and therefore were composed of process and impact deliverables. Activities included: revising the current ART HR planning guidelines to include home based care; supporting provincial staff to orient districts on ART HR planning guidelines; supporting 20 districts to plan for HR requirements for delivering HIV/AIDS services; supporting MOH to track the implementation of the 5-year HR plan; supporting integration of HR in HMIS; supporting training of central level and provincial HR and HMIS in HR/HMIS modules; developing and disseminating retention guidelines; supporting the operations of the HR task force; assisting MOH to redeploy staff to areas of need; recruiting and supporting 35 medical doctors on the rural retention scheme; providing ongoing support to Clinical Care Specialists; supporting training and follow up of graduating students; supporting revision of curricula; work with JHPIEGO to develop an onsite training package for HIV/AIDS co-infection; supporting the implementation of national in-service training coordination system; supporting the design of TIMS; and supporting development and implementation of an accreditation system.

#### 5.2.1 Accomplishments, Human Resource Planning and Management

##### ART, PMTCT, CTC and HBC HR planning guideline developed:

TA was provided to expand the ART, PMTCT and CTC HR planning guidelines to include Home Based Care (HBC). The guidelines were piloted in 9 districts i.e., Kitwe, Ndola, Solwezi, Chingola, Chipata, Katete, Petauke, Livingstone and Kazungula. The feedback from the pilot was used to

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finalize the guidelines. Currently the guidelines are being type – set for final printing and dissemination. 5 MoH and 18 PHO HR Specialists/officers will be oriented to the guidelines in year 3. The guidelines provide step by step instructions on how to estimate the staff requirement to deliver a minimum package of HIV/AIDS services.

### National HRH Strategic Plan revised and implemented:

Most of the year focused on the revision and implementation of the 5 year plan for Human Resources for Health (HRH). The revisions took into account the comments from stakeholders who recommended for inclusion of the epidemiological factors in the situation analysis, recognizing community participation, and the contribution of the private sector and church health institutions. The first year activities of the 5 year HRH plan were implemented and a progress report presented at the Policy meeting in August 2006. Some of the quick wins noted included: -

### Quick wins in implementing the Human Resources for Health (HRH) plan:

- Approval of the New MoH Establishment – this will necessitate the recruited of 1900 health workers in 2007
- Increments in On Call Allowances – The more than 100% increments increased the amount of disposable income available to doctors.
- Expansion of the Zambia Health Worker Retention Scheme (ZHWRS) – support amounting to K609 Billion by the Netherlands and SIDA. \$2.5 Million was released for 2006. This in addition to other resources will give an opportunity to expand the ZHWRS to other critical cadres.
- All 2005 graduates recruited (690) – The freeze on employment led to a number of graduates roaming the streets, engaging in petty trading and/or leaving the country.
- All 30 PBN students sponsored by USAID & bonded
- 23 PBN (2005) graduates posted 2 per Nursing School

### 72 Districts Action Plans reviewed and Southern Province supported during 2006 annual planning:

The HR team participated in the review of the 72 district action plans to ensure that districts adequately planned for human resource in order to deliver the minimum package of health services. The report revealed that despite the HR crisis very few districts had objectives and activities to address human resource issues. During the 2006 annual review and action planning HSSP supported Southern Province to ensure that the targeted 11 districts include HR objectives and activities in their plans.

### Memorandum of Understanding (MoU) for HSSP supported retention scheme developed:

HSSP also worked with MoH to finalize a Memorandum of Understanding (MoU) which spells out the terms and conditions of an HSSP supported Retention Scheme. During the year under review the MoH with consensus from other stakeholders revised the retention allowances upward. As a result of this development HSSP will now support 23 doctors, 22 nurses, 22 COs, 9 pharmacy staff, 10 laboratory technicians and 33 nurse tutors. The HSSP supported Retention Schemes will now be implemented in the first quarter of year 3. The implementation of the retention scheme will lead an expansion of HIV/AIDS services in the 54 rural C and D districts.

Staff retention guidelines developed:

In addition to the MoU HSSP worked with MoH to finalize Retention guidelines that will be shared with other stakeholders in the first quarter of year 3. The retention guidelines will be the standard document that will guide hospitals and districts to plan and execute incentive schemes in the public health sector.

Human Resource chapters in the Global Fund proposals for Round 4 reprogramming and Round 6 developed:

One major activity that HSSP participated in was the development of the HR chapters for the Global Fund proposals for Round 4 reprogramming and Round 6. Both proposals were finalized and presented to the Global Fund for HIV/AIDS, Malaria and TB. These two proposals spell out the critical strategies and resources required to address the current HR crisis and boost retention of health workers in the sector. In addition this was an opportunity to mobilize resources to fund activities in the 5 Year HRH plan.

### 5.2.2 Key Results

- 5 Year HRH Plan revised
- HIV/AIDS HR Planning Guidelines with HBC developed
- 72 District Action Plans reviewed for HR objective and activities
- Memorandum of Understanding for Doctors' Retention Scheme developed
- Retention Guidelines developed
- HRH Plan Year 1 activities implemented and Progress Report developed.

### 5.2.3 Activities not accomplished

- In light of the HSSP project redefinition, activities relating to Human Resource Information Systems (HRIS) were dropped. Nevertheless HSSP provided TA to develop the HMIS HR tools. Some of the tools have since been incorporated in the District Action Plans. In addition the tools will be availed to the HMIS Review Team during the HMIS review process. The training of HR staff to utilize the tools will be done once the whole HMIS has been reviewed.
- TIMS will not be implemented because it can not interface with other software. With this system different information can not be merged and aggregated at national level. It is not a preferred system by MOH.

### 5.2.4 Accomplishments - Pre and In-Service Training

Core competencies document for HIV/AIDS service delivery developed:

The HR team worked with MOH, Statutory boards training institutions and other stakeholders to finalize the core competencies for HIV/AIDS service delivery. The document, which spells out specific competences for each cadre for the provision of HIV/AIDS services, is being used in curriculum reviews. 500 copies have been printed and awaiting dissemination by the MoH.

General Nursing Council's (GNC) report on the evaluation of nurse training institutions developed:

HSSP provided support to GNC to analyze data and write a report on implementation of curriculum. The purpose of the evaluation was to assess the extent to which HIV/AIDS was incorporated in curricula.

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### 154 graduates and faculty trained in ARV, OI, and PMTCT management:

This was a continuation from year 1 of the short-term strategy to ensure that graduating students are trained to provide the services while working in the longer-term to integrate training into the curricula. Among those trained were 20 Students, from Lusaka Theatre Nursing School, 78 Student Midwives from Lusaka and Ndola Schools of Midwifery, 27 Student Nurses from Chipata School of Nursing, and 29 faculties from Chainama College, Lusaka School of Nursing and Katete St. Francis Hospital. Lecturers were trained at the same time with student midwives in order to build capacities for them to be able to teach students as the Midwifery curriculum was already reviewed to integrate HIV/AIDS. Competency based training was also conducted for Chainama College faculty to strengthen lecturers skills in clinical training. 154 graduates and faculty underwent training in 2005/2006, bringing the cumulative total from year 1 to 846. Out of these, 158 were faculty. Development of tools for follow up of the graduates trained is on going; more than 200 graduates have been located. More than 50% professionals trained here were females. This is because the majority was nurses and nursing is still dominated by females.

### Training needs assessment for Chainama conducted:

Under the long term strategy, HSSP supported Chainama College to conduct a training needs assessment (TNA) for Clinical Training Sites prior to curriculum review for Clinical Officer General (COG) and Environmental Health Technologists (EHTs).

### Clinical Officer General (COG) and Environmental Health Technician Curricula revised:

HSSP worked with Chainama College to revise the COG Curriculum and the college has since used the experience gained to revise the EHTs curriculum to incorporate HIV/AIDS and other emerging issues on priority health services. Implementation of the revised curriculum will ensure that the annual intake of 120 Clinical Officer General will graduate with knowledge and skills to provide HIV/AIDS services. A Lecturers' Activity Guide for COG curriculum was also developed. This document will guide how the content of curriculum will be taught.

### Consensus reached with the school of Medicine to revise the curriculum:

A consensus has been reached with the School of Medicine to revise the curriculum and incorporate HIV/AIDS and other priority health services. HSSP will now let the School of Medicine lead the process of their curriculum review, including mobilizing resources for the same. This activity will not be supported by HSSP.

### Curricula for Health Care Assistant (HCA) and Library Management Course (LMC developed):

HSSP also worked with MOH in developing curricula for Health Care Assistant (HCA) and Library Management Course (LMC). MOH has proposed to introduce HCA to bridge the gaps in shortage of staff for direct patient care, where as the LMC will enhance development and improvement of skills for staff managing libraries in training institutions.

### Teaching models and materials given to Kitwe School of Midwifery:

HSSP also supported the newly opened Kitwe School of Midwifery with teaching models and materials; this will strengthen transfer of practical skills to students.

### National In- Service Coordination System (NITCS) and National Training Guidelines (NTGs) developed:

Under the in-service training component HSSP worked with MoH to finalize National In- Service Coordination System (NITCS) and National Training Guidelines (NTGs)- activity continued from year 1. 400 copies of NITCS were printed. The MOH's Permanent Secretary launched both documents in August 2006. The NITCS will ensure coordination of training activities overall,

while the NTGs will ensure standardized coordination of both pre and in-service training programmes at all levels. In an effort to introduce the new system HSSP provided TA in the orientation of Provincial Health Directors, Human Resource Managers and District Directors of Health. More orientation and related support may be needed to ensure implementation.

*An accreditation system for private and public ART providers developed:*

Regarding Support Supervision, the HR team worked with Health Systems Planning to provide technical assistance to MOH to develop an accreditation system for private and public ART providers. Under this activity HSSP provided TA to MoH and Medical Council Zambia (MCZ) to revise the Medical and Allied Professions Act. Consensus was reached to give the responsibility of accreditation to MCZ. Furthermore guidelines and tools for accreditation were also developed. This activity will now fall under the Performance Improvement component of the revised HSSP.

**5.2.5 Key results**

- 154 graduates and faculty trained in ARV, OI, and PMTCT management:
- Core competences developed and 500 copies of the document printed
- Revised COG curriculum
- Teachers/Lecturers Activity Guide developed
- National In-service Training Coordination System (NITCS) and National Training
- Guidelines (NTGs) developed and launched by MOH.
- Guidelines for accreditation system developed

\*In light of the HSSP program restructuring, activities relating to Human Resource Information Systems (HRIS) have been dropped. Monitoring adherence to use of national treatment protocols (ART and opportunistic infections) has also been dropped. Activities, under accreditation have been moved to Performance management, a new technical area. Performance management will support MOH in analyzing and documenting quality of supervision; reviewing the performance assessment and technical support supervision tools; and supporting accreditation of ART delivery sites.

### 5.3 Policy

HSSP's support in year one (2004/2005) was to provide technical assistance to the MoH in the drafting of various health policies including the National HIV/AIDS/STI/TB Policy, the National Integrated Reproductive Health (IRH) Policy, the National Health Research Policy, the National Child Health (CH) Policy and the National Health Care Financing (HCF) Policy; setting the 2005 MoH Policy and Legislation Agenda; and training of 10 MOH Chief Policy Analysts in monitoring and evaluation skills as a way of strengthening the Ministry's institutional capacity to track the status of implementation of approved policies and pieces of health legislation.

In year 2 (2005/2006) HSSP' role was to ensure ratification and monitoring and evaluation of approved health policies; strengthening of the policy and regulatory environment; strengthening of the annual Policy and Legislation Agenda setting and review mechanism; and facilitation of the development, approval through Cabinet and implementation of health policies (IRH, CH, Nutrition, and HCF) that were not finalized in year one.

Changes in Ministers for the sector delayed approval of some policies and legislature as the new ministers had to again read through these documents before they could ratify them. Four policies were affected.

This being an election year progress on approvals by cabinet tended to be slow as attention was diverted towards preparing for the elections.

#### 5.3.1 Accomplishments

##### HIV/AIDS/STI/TB policy ratified:

Among the major achievements is the completion and approval by Cabinet of the HIV/AIDS/STI/TB policy. The MOH is preparing to launch the policy before end of 2006. The policy is expected to provide the requisite framework for informing and guiding all the stakeholders in their efforts to fight against HIV/AIDS/STI/TB.

##### Status of Other policies:

The Health Care Financing policy was developed but has not yet been submitted to Cabinet for approval. A Cabinet Memo and Implementation Plan for the Child Health Policy were prepared and submitted to Cabinet. However, the policy has not yet been endorsed due to the dissolution of Cabinet which means that the policy will have to be re-circulated. The Reproductive Health policy will also be re-circulated. HSSP facilitated the development and submission to Cabinet of the National Nutrition Policy. This policy has been approved and is already in print.

##### Monitoring and Evaluation indicators and 2006 National Policy Legislation Agenda developed:

The monitoring and evaluation indicators to monitor the implementation of approved policies have been developed. The status of implementation of the National Medical Laboratory Policy vis-à-vis planned M & E indicators with a focus on HIV/AIDS was reviewed. 2006 National Policy and Legislation Agenda were printed and 10 copies submitted to MOH. These accomplishments have provided a favorable environment for addressing priority health issues.

### 5.3.2 Key results

- National HIV/AIDS/STI/TB Policy approved by Cabinet
- 2006 Policy and Legislation Agenda set
- Reproductive Health and Child Health policies submitted to Cabinet
- Monitoring and Evaluation indicators for monitoring health policies developed

\*The position of Health Policy specialist in HSSP was dropped in August 2006. Therefore, HSSP's policy support to the Ministry of Health has been revised. HSSP will not support further policy development. Only defined aspects (support to implementation and monitoring and evaluation of approved policies) will be implemented under the Sector Wide Approaches (SWAPs).

#### 5.4 HIV/AIDS Treatment: ARV Drugs

HSSP's original mandate was to support the ministry in the area of drugs and logistics. However, with the coming on board of JSI/DELIVER HSSP shifted its attention towards supporting the establishment of the pharmacovigilance centre and development of the national framework for monitoring ARV drug resistance. Therefore, HSSP's support to ARV drugs component in 2005/2006 was in the area of training ART sites in Adverse Drug Reaction/ Events reporting; strengthening implementation of the ADR/E reporting; and strengthening the system for ARV drug resistance monitoring.

Activities to achieve these objectives included: designing and review of protocols and forms for HIV/AIDS, TB, Malaria, and EPI; facilitation of approval and dissemination of the forms and protocols; development of training materials for the provincial TOT and district training sessions; conducting provincial Training of Trainers workshop; supporting district training (training materials and follow up); supporting technical training for key national pharmacovigilance unit (NPVU) staff in data management; providing technical assistance and logistical support for the operational systems of the NPVU; completion and approval of the conceptual framework for monitoring ARV drug resistance; and establishing roles and responsibilities for drug resistance.

The delayed completion of the PRA structure made it very difficult to implement certain activities in the area of pharmacovigilance. Current PRA staff is overstretched with routine PRA activities. Lack of a focal person at the NPVU might stall start-up activities needed to make the Unit functional.

##### 5.4.1 Accomplishments

###### Lab/sample forms for HIV/AIDS, TB, Malaria and EPI developed:

Lab/sample forms for HIV/AIDS, TB, Malaria and EPI were developed and adopted by the Pharmacovigilance Centre Technical Working Group and the Ministry of Health. 1,500 copies of each of the HIV, TB and Malaria lab sampling forms were printed. The forms will facilitate standardization of collection of samples of all suspected cases of resistance and ADR/E at the various levels of the health system.

###### Guidelines for detecting and reporting Adverse Drug Reaction/Events (ADR/Es) for HIV/AIDS, TB, Malaria and EPI, developed:

Guidelines for detecting and reporting Adverse Drug Reaction/Events (ADR/Es) for HIV/AIDS, TB, Malaria and EPI, have also been developed. These forms will facilitate operationalization of the national drug resistance reporting system, which was recently finalized and subsequently adopted by Pharmaceutical Regulation Authority (PRA).

###### The National Pharmacovigilance Unit (NPVU) launched:

The National Pharmacovigilance Unit (NPVU) was launched in June 2006 by the Ministry of Health. The launch provided an opportunity to sensitize the public and private sectors on the importance of ARV pharmacovigilance.

Reference Manuals and requisite forms for the Pharmacovigilance unit developed:

1,500 copies of Pharmacovigilance Reference Manuals; 1,500 copies of Pharmacovigilance Protocols; and 1,500 copies of the ADR/E forms were printed for use in the health facilities to report the adverse reactions.

64 health workers trained in Pharmacovigilance:

Three Pharmacovigilance TOT Workshops were conducted at national level. This included clinicians, Pharmacists, Pharmacy/Lab Technologists, Biomedical Scientists, Clinical Care Specialists, Data Management Specialists and Provincial Surveillance focal persons from all provinces (public sector), NGO's, Government Defense Forces, Private Sector and Tertiary Hospitals (public sector). A total of 64 health workers were trained. The PVC forms and protocols were disseminated at this forum. PVC Guidelines were reviewed again after the national workshops to incorporate salient views arising and later printed, together with the developed Reference Manuals. The next step is for provinces to facilitate district level training.

HIV Drug Resistance (HDR) monitoring framework developed:

The HIV Drug Resistance (HDR) monitoring framework was developed, and awaits adoption by the HDR technical working group. The development of HDR monitoring implementation Plan with a budget including financing sources and gaps was initiated. This will be finalized in the 1st quarter of FY 2006. Resource mobilization from partners and other donors has been the mainstay for ADR/E activities given the limited finances allocated to this component.

#### 5.4.2 Key Results

- 64 health workers trained in Pharmacovigilance
- Guidelines for detecting and reporting Adverse Drug Reaction/Events (ADR/Es) for HIV/AIDS, TB, Malaria and EPI developed
- National Pharmacovigilance Unit (NPVU) Launched
- Lab sampling forms for ADR/E were developed
- Reference Manuals developed and printed

The position of Drugs and Logistics Advisor in HSSP was dropped in August 2006. Only Pharmacovigilance and HIV drug resistance monitoring activities will be implemented up to the end of year 3 after which this component will be completely dropped. The ARV drugs component will be institutionalized within the PRA to ensure continuation of activities.

#### 5.4.3 Activities not implemented

The following activities were not implemented and will be supported in the third year: technical training for key NPVU staff in data management; provision of technical assistance and logistical support for the operational systems of the NPVU; and completion of the HDR monitoring implementation plan. HSSP will provide financial and technical assistance for implementation of the above the FY2006 activities.

## 5.5 Health Financing

The overall objective in the area of Health Care Financing in 2005/2006 was to ensure that all districts are reporting HIV/AIDS service expenditures and planning for sustainability of ART services.

Activities to achieve this objective included: providing guidance on the costing and budgeting for the minimum package of HIV/AIDS services; supporting MOH to ensure that the District Accounting System captures and reports HIV/AIDS services related expenditure; working with NAC to develop a resource tracking mechanism for HIV/AIDS; developing a sustainability framework to estimate the cost of ART and other HIV/AIDS service provision; and costing of the National Health Strategic Plan, 2006-2010 by collating data from the various technical areas.

### 5.5.1 Accomplishments

#### Costing and Budgeting Guidelines developed:

The Costing and Budgeting Guidelines have been finalized. The guidelines will be used by all 72 districts to improve the budgeting and costing skills of all district managers.

#### District Accounting System has been developed; 9 financial specialists oriented:

A District Accounting System (DAS) has been developed as a tool for recording the flow of funding to the district health system in all 72 districts. HSSP further supported the orientation of 9 financial specialists one per province on the DAS. These will in turn provide technical support to the 72 districts.

#### National Health Strategic Plan (NHSP) 2006/10 costed:

HSSP provided technical assistance (local and external STTA) in the costing of the NHSP 2006/10. A technical team, which consists of staff from both HSSP and MoH, was organized to perform the cost and financing study. The current National Health Strategic Plan, (NHSP) covers the period from 2006 to 2010. Unlike all previous NHSP documents the current plan is costed. In addition, the projected availability of funds over the planning period is identified. The potential financing gaps are also highlighted based on the estimated cost or financing need of the entire plan and the financing available for implementing the NHSP. Furthermore, the strategies for filling the financing gaps are recommended.

#### Abolition of user fees in rural areas

HSSP was also instrumental in developing guidelines for implementing the Government's policy to abolish user fees in rural areas. The user fees were abolished in the 54 rural districts. Guidelines were therefore necessary to guide the implementation and define the way forward regarding compensation for lost User Fees revenues by districts.

### 5.5.2 Key results

- District Accounting System (DAS) developed
- 9 financial specialists oriented on the DAS
- Costing and Budgeting Guidelines developed
- NHSP 2006/10 costed
- Guidelines for implementing the removal of user fees policy developed

\*In view of the revised program description, the position of Health Care Financing Specialist has been abolished and only certain aspects of Health Care Financing will be implemented under the SWAPs technical area in 2006/2007 i.e., supporting National Health Accounts (NHA) HIV/AIDS sub-analysis; and developing a sustainability framework to estimate the cost of ART and other HIV/AIDS service provision.

## 5.6 HIV/AIDS Coordination/SWAP

HSSP's support to HIV/AIDS coordination/SWAP in 2005/2006 was through TA to MOH to ensure that HIV/AIDS services were integrated into SWAP; ensure that 20 districts were offering a minimum package of HIV/AIDS services; 2006-2008 ART implementation plan was developed; HIV/AIDS resource mobilization was supported; partnerships for HIV/AIDS and the HIV/AIDS referral system are strengthened; and HSSP HIV/AIDS activities were coordinated.

Activities to achieve these objectives included: supporting finalization and approval of the Basic Health Care Package (BHCP); development of the framework for tracking implementation of the HIV/AIDS activities in the NHSP; assessing provision of a minimum package of HIV/AIDS services in districts; supporting the review of the 2004/5 ART plan and developing the 2006/8 plan; supporting development of GFATM proposals; finalizing and maintaining the ART database establishment; supporting development of a referral system for public and private sector delivery of HIV/AIDS; documentation of PEPFAR activities; and coordinating the HIV/AIDS workplace program.

### 5.6.1 Accomplishments

#### Plan for completion of the BHCP developed and implemented:

The BHCP Technical Working Group (TWG) was reconstituted by the Ministry of Health. The TWG plays an advisory role in the development of the national BHCP. HSSP provided financial and technical assistance for the review of the BHCP. The STTA was recruited with funding from HSSP and has since commenced the review process with participation of the TWG. The BHCP is a strategic contribution to the health sector planning. The first edition of the consolidated BHCP for three levels of health care (1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> levels) will be developed by end of October 2006 after which a road map to finalize the BHCP development will be developed. The TWG with membership from various stakeholders has scheduled periodic meetings to review the drafts from the consultant. World Health Organization has pledged to support the process by recruiting one external consultant and supporting part of the logistics.

#### 2004/5 ART implementation plan evaluated and 2006/8 plan developed:

HSSP supported the MoH to conduct an evaluation of the 2004/2005 ART implementation plan. The following are some of the key findings of the evaluation: the national 2004/2005 ART plan was well disseminated at the central level but not at the lower levels; All service sites were providing ART services with the number of clients increasing from 12,000 in 2004 to 46,000 at the time of the evaluation; 94% of facilities reported that health workers involved in ART had been trained; less than half of the sites were adequately equipped to provide laboratory and pharmacy ART services; and about half of the implementing facilities reported having a forum for information sharing (inadequate coordination of HIV/AIDS services). The program scored a number of achievements as follows: the high enrolment rates of patients on to the ART program; increased quality of ART services evidenced from the large numbers of trained providers; and free ART policy was implemented in all sites. However, there were challenges observed in the implementation of the program. The ART program was initiated before all management systems were put in place; shortage of human resource; providers did not have enough guidance on ART implementation due to inadequate dissemination of the plan; stigma still prevented a lot of people from accessing the service.

Recommendations were made based on these results and were used to develop the successor plan for 2006/8. Technical updates were derived from this plan and used for development of institutional work plans in all 72 districts. The plan is now ready for printing. HSSP will print 1000 copies. This will be followed by a national dissemination. Provinces will be expected to disseminate up to district and health centre levels.

ART partners' database developed:

The MoH ART partners' database was finalized and data collection from the Cooperating Partners commenced. This will allow for coordination of partner ART services support. Partner ART reports will be generated bi-annually. The database will be maintained within the Ministry of Health. However, partners are reluctant to release their data.

GFATM round 6 proposal developed:

HSSP provided technical assistance to the Ministry of Health and National AIDS Council towards conceptualization and planning for the Round 6 GFATM proposal and reprogramming of Round 4 phase II funds. HSSP participated in the identification of priority areas (procurement of ARVs, expansion of human resource base, and procurement of laboratory reagents and engagement of the community in HIV/AIDS activities) for inclusion in the Round six proposal and round 4 phase II funds reprogramming. All HSSP technical specialists were mobilized to offer technical assistance in various areas of their operation and ensured that their activities were reflected in the GFATM proposal and work plans. The proposal was submitted to Global Fund for consideration in August 2006.

HSSP HIV/AIDS workplace needs assessment conducted:

HSSP HIV/AIDS workplace needs assessment was conducted aimed at improving the institutional HIV/AIDS programme and a report was developed. Key findings from the report suggested that utilization of the available services was very low because members of staff thought they could access these elsewhere. Confidentiality was also mentioned to be a hindrance to accessing HIV/AIDS workplace services. Other activities implemented are the provision of IEC materials to members of staff; conducting recreational activities; and ensuring that both female and male condoms are replenished in bathrooms.

Contribution to SWAP coordination

HSSP provided financial support to the SWAP coordinating officer in the Ministry of Health. Roles included assisting MOH in the coordination and preparation of Policy Committee meetings, providing logistical support to the MOH/cooperating partners' meetings; participating and providing secretarial services to the Health Care Financing and Monitoring and Evaluation meetings; supporting the planning directorate in the collection of data for planning and development of requisite tools for public expenditure tracking systems.

National Health Strategic Plan (NHSP) 2006/10 developed:

HSSP provided technical assistance in the conceptualization; drafting and costing of the NHSP 2006/10 (see details on costing under Health Care Financing). All HSSP technical specialists were mobilized to offer technical assistance in their areas of operation/expertise and ensured that their areas were adequately reflected in the new strategic plan. HSSP supported one consultant in the drafting and proof reading of the document to ensure quality control of the plan. The NHSP 2006/10 will enable the ministry of health to manage the sector in an efficient manner that would lead to improved service delivery.

### 5.6.2 Key results

- The National ART Implementation Plan 2004-2005 evaluation report
- HIV Care and ART services plan for 2006/8 developed
- ART partners' database
- Round 6 GFATM proposal and plans for reprogrammed Round 4 phase II funds developed
- HSSP HIV/AIDS workplace needs assessment report developed
- SWAP activities in the health sector coordinated
- NHSP 2006 to 2010 developed

*\*Activities not implemented (to be implemented in 2006/7 under the FY2006 funding):*

The following activities were reprogrammed and will be implemented in 2006/2007 fiscal year: development of the framework for tracking implementation of the HIV/AIDS activities in the NHSP; assessing provision of a minimum package of HIV/AIDS services in districts; and supporting development of referral mechanism procedures for public and private sector delivery of HIV/AIDS. These activities are part of the FY2006 country operational plan.

#### ***Next steps for 2006/2007***

HSSP will continue to strengthen the program management and coordination for health sector HIV/AIDS services; integrating HIV/AIDS into SWAP; and coordinating HSSP HIV/AIDS services.

## 5.7 Health Management Information System

In 2005/2006, HSSP' mandate is supporting districts to use Routine Health Information System (RHIS) to plan and manage HIV/AIDS services; rolling out ARTIS to private ART centers; and strengthening the HMIS system.

Activities to achieve these objectives include: supporting revision of HMIS to integrate CTC, PMTCT and TB; training of 81 data managers in the revised tools; supporting revision of HMIS database program to incorporate PMTCT, CTC, TB and ART; supporting the design and implementation of a data collection mechanism for laboratory and home based care activities; developing an abridged version of ARTIS materials for use in private facilities; training 63 private facility health workers; supporting publication of HIV/AIDS related data and other information; and providing technical assistance to MOH in the overall HMIS review.

The restructuring process at the MoH coupled by reduced funding led to non-implementation of some of the planned activities e.g. training of 96 non-data managers in data use for planning and 81 district staff in PMTCT/VCT tools and the same activities may not be fully implemented during the coming year due to budget constraints.

Lack of leadership from the MoH led to duplication and slowing down of work.

### 5.7.1 Accomplishments

#### PMTCT/CTC framework developed:

HSSP has been supporting the integration of PMTCT/CTC into the mainstream HMIS. A conceptual framework for PMTCT/CTC was developed based on the PMTCT operational guidelines. This framework serves to provide a common understanding on the standard practice for provision of PMTCT/CTC services. However the framework still requires further revision in view of pediatric HIV issues that need to be incorporated. The framework provides the basis for development of the M&E framework for PMTCT/CTC services. A list of TB indicators is underdevelopment.

#### Manuals and prototype training slides developed:

Indicators manual; procedures manual; and prototype training slides have been developed. District and provincial data managers will be trained in the use of the revised PMTCT/CTC tools in 2005/2006.

#### HMIS indicators reviewed:

HSSP was also involved in the general HMIS review. Input was provided to the HMIS review team in the review of the existing HMIS indicators and drafting of the budget to cover the remaining phases (redesign and rollout). The MOH is revising the HMIS with support from the European Union and other stakeholders.

#### ART Electronic Patient Record institutionalized:

Further support was provided for the institutionalization of Electronic Patient Record system for ART. The process resulted in streamlining of the CIRDZ originated data tools to make them

national tools and the designing of the paper format of the quarterly reports for ART which has since been incorporated into the Patient Tracking System. The MOH has adopted the Patient Tracking System as a national system for tracking HIV/AIDS services for all facilities with the capability to implement the electronic system and ARTIS paper based system for those without. HSSP has been working with MOH and CDC to ensure that appropriate standards are included in the new software.

Presentation made at ICASA 2005 Conference: "ART Information System in the levels 2 and 3 hospitals of Zambia":

During the December 2005 ICASA conference, HSSP was represented by the HMIS component and made a presentation on ART Information System in the levels 2 and 3 hospitals of Zambia.

### 5.7.2 Key results

- PMTCT/CTC framework developed
- Manuals and prototype training slides developed
- HMIS indicators reviewed
- ART Electronic Patient Record institutionalized

Activities not implemented

The following activities have not been implemented due to changes in the ministry's policy to adopt one system for tracking HIV/AIDS services at service provision level: supporting the design and implementation of a database collection mechanism for laboratory and home based care services; developing an abridged version of ARTIS materials for use in private facilities; and training of 63 private facility health workers.

***Next steps***

Focus will be on ensuring that 90% of districts are demonstrating appropriate use of data in planning for HIV/AIDS.

## 5.8 Planning for HIV/AIDS Services

In 2005/2006 emphasis is to ensure that all district plans include the minimum package of HIV/AIDS services and are using revised planning guidelines during planning; and capacity in data use for districts and hospitals is strengthened.

Activities to achieve these objectives were supporting development of the addendum for the minimum package of HIV/AIDS services; consolidating technical updates for annual sector planning; supporting provinces and districts to capture HIV/AIDS services in the annual plans; developing a data reference manual for action planning, implementation and reporting; and analyzing all district and hospital plans for improved use of data.

### 5.8.1 Accomplishments

#### District/Hospital Action Plans reviewed:

HSSP supported the Ministry of Health to conduct a desk review of the 2006-08 action plans for 72 districts and 22 second/third level referral hospitals. The purpose of the review was to assess whether the plans contain key elements to deliver the minimum package of health care services including HIV/AIDS and to assess levels of adherence by planners to the guidance provided through the planning guidelines and identify gaps. The review revealed, among other concerns, that all the plans covered key elements of the Basic Health Care Package. There was also a remarkable improvement in planning for HIV/AIDS services by most districts although more guidance is still required in selection of appropriate interventions. The findings also revealed inadequate use of data for planning. Monitoring and Evaluation in most cases needed focused support.

The desk review was well appreciated by the MoH. “We have never conducted a review of District Action Plans before, but through HSSP support we have managed to do this and the results have forced us to adopt “Marginal Budgeting for Bottlenecks” – said the Director Planning & Development-MoH”. This approach encourages planners to be more analytical and results oriented.

#### Reviewer’s tool updated:

The main activities conducted included technical support (TS) to provincial health offices (PHOs), during the launch of the 2007 planning cycle for their respective districts. Tools for reviewing final district plans were also updated and sent to all the nine PHOs, 72 districts, 22 hospitals and 22 training institutions. This approach gave the institutions an opportunity to assess themselves and begin to address identified gaps in their plans in relation to key health interventions prior to the final review by the PHOs/ MoH-HQ. The tools were reported by most PHOs and districts to have been very helpful during the development of the institutional plans. Further TS was provided to nine PHOs for the review of district/hospital health plans in readiness for the consolidation of the health sector plan.

#### Planning Technical updates developed and disseminated:

The documents were used as reference materials by institutions during development of their 2007/09 action plans.

72 districts supported to develop their 2007/09 action plans:

Through combined HSSP & MoH effort, 9 PHOs and 72 received support during provincial/district planning meetings and information received was used by districts/hospitals to develop their 2007-09 action plans. Further more, HSSP & MoH provided technical guidance/direction to all 9 PHOs, 72 districts, 22 hospitals and 22 Training Institutions during the review of the 2007-09 district action plans. The feedback provided to institutions enabled them to finalise their plans for 2007-09.

**5.8.2 Key results**

- 72 districts, 22 hospitals & 22 Training Institutions received direct technical support and feedback in development of their action plans.
- Reviewer's tools updated and used for 2007/09 planning.
- 72 District and 22 Hospital Action Plans reviewed and feedback provided.

***Next steps***

HSSP's support in 2006/2007 will be on ensuring that districts are using revised planning guidelines and tools to plan for HIV/AIDS; and are reporting progress on action plans.

## 6 Clinical Care Specialists

One new and very positive component of HSSP's work during the year was the addition of nine Clinical Care Specialists to the staff. These are nine Zambian Physicians, three of whom were recruited back to Zambia from abroad, who are placed in the nine Provincial Health Offices. Their primary role is to improve the quality of clinical care and "technical support supervision" (TSS) with a special emphasis on the delivery of HIV/AIDS services. The Clinical Care Specialists (CCSs) take their technical supervision from the Provincial Health Director on whose staff they serve, and their administrative supervision from HSSP. However, their job descriptions, role, and responsibilities were clearly defined in advance and monthly activity reports are submitted to HSSP. The "HSSP CCS" is teamed with one other non-physician CCS in each provincial office. Together, these two people provide a majority of the clinically-oriented supervision that gets done with the District Health Management Teams (DHMTs) and the district hospitals.

To a large extent, the CCSs are becoming the "eyes and ears" of HSSP, and for the ministry as a whole. They are problem finders and solvers. Until their arrival, most "supervision" within the system was primarily an auditing function to monitor compliance with regulations, check equipment, and monitor supplies with less emphasis on clinical care due to time and other limiting factors. The new CCSs are now enabling the Provincial Health Offices to offer more comprehensive support to the DHMTs.

One interesting aspect of the CCS's work falls in the area of HIV/AIDS service delivery that is *outside* of the work supported by the "main" USG-supported programs. CIDRZ and ZPCT work primarily in larger population centers where they can get "the numbers" required by PEPFAR. Our CCSs are beginning to support government efforts to provide HIV/AIDS services in the smaller, more rural, and more out-of-the-way places where HIV-infected individuals live and need services. They are providing training, making linkages, and in some cases facilitating the establishment of once-a-month clinics to provide service where it did not formerly exist.

### 6.1 Accomplishments

#### 131 health staff trained:

23 health workers were trained in HIV counseling, 65 in ART and opportunistic infections; and 18 ART health care providers were trained in adherence counseling, in coordination with Kara counseling and ZPCT in Central and Western provinces. 25 providers were trained in PMTCT in Luapula province.

#### Site assessments for ART readiness conducted:

In collaboration with CIDRZ, ART site assessments were successfully completed in some remote districts of western provinces and ART services are now provided after the requisite capacity issues were addressed. Shan'gombo district in western province is one of the remotest districts in Zambia and is now a beneficiary of ART services. PMTCT has also been scaled up to 13 more centers in Western province. Pre ART site assessments have taken place in other provinces as well.

#### District action plans developed

CCSs facilitated coordination of district action planning for priority health services with a focus on HIV/AIDS services. District action plans have been finalized and are being submitted to Ministry of Health for approval.

Technical Support Supervision (TSS) visits successfully conducted in all provinces:

TSS supervision visits were regularly conducted to support hospitals in their provision of HIV/AIDS services. Quality control in TB management has been recognized to be of great importance, especially regarding sputum examination. Therefore, TB cohort quarterly review meetings have been initiated in Central province. Advocacy for an improved link between TB clinics and CTC centers has started. Consequently, there has been a notable increase in the number of TB patients undergoing CTC. The same is the case in western province.

ART sites Evaluated in four provinces:

Evaluation of ART sites was conducted in 4 provinces (Eastern, Copperbelt, North Western and Luapula). The purpose was to define and address gaps in the current service provision and identify useful lessons in the scale up of ART. Among the key findings was the fact that the ART and pediatric HIV/AIDS trained staff need regular updates to keep abreast with emerging issues and approaches. Generally there was inadequate trained staff for delivering ART services, laboratory facilities in most of the sites were below expected minimal standards. Facilities did not have adequate storage capacity for drugs. Drugs and logistics management e.g. quantification, ordering, was insufficient.

PMTCT services in Lusaka province assessed

PMTCT services in Lusaka Province have been provided since 1997. Currently all the four districts in the province are offering PMTCT services. However, follow up action to assess the quality of PMTCT has not been done. The provincial health office undertook an assessment in August 2006. The following were some of the findings: all centres visited had job aids for both Abbott and Genie II as these come with the test kits. However, only one centre had the new PMTCT protocols (in draft form). The centers neither had the general psychosocial counseling guidelines nor PMTCT guidelines available in the counseling rooms. Staff has personal copies kept at home. Most counseling rooms and MCH areas did not have IEC materials displayed.

Coordination Strengthening:

CCSs have been instrumental in facilitating the formation of provincial HIV/AIDS ART committees (membership comprises various stakeholders) whose major role is to coordinate HIV/AIDS service provision in the provinces. All the nine provinces have ART committees. The CCSs are working towards ensuring that meetings are held regularly.

## **7 The Luapula Project**

Luapula Province faces many constraints in delivering health services to the community. Some of the major constraints are:- Poor transport and lack of adequate communication facilities, inadequate safe water supply, poor sanitation facilities, inadequate medical equipment and supplies and dilapidated infrastructure in most of the districts. In addition, there is a critical human resource crisis resulting into some of the centres being run by Casual Daily Employees (CDE's)

USAID made funds available towards these needs in an endeavor to enhance the health services delivery system in the province.

The Luapula Project therefore was mooted out of this background in March 2005. HSSP conducted a needs assessment to identify specific areas of support in all the seven districts of the Luapula Province. The main areas of need, which became the focus in the Luapula project include

addressing the health transport needs, medical equipment, communication, infrastructure rehabilitation and solar electrification and provision of safe water.

## 7.1 Accomplishments

The identified needs therefore were translated into the major components of the Luapula Project as follows:-

### 29 staff housing units and 2 Health Centres successfully rehabilitated:

Under the Luapula Project, a total of 29 staff housing units and 2 Health Centres were successfully rehabilitated within 10 days during the month of September 2005. The rehabilitation component concentrated mainly on mending cracks in walls of selected health infrastructure, roofing, replacements of broken window panes, window frames, doors, door frames, taps, toilet cisterns, ceiling board, interior painting and exterior rough cast of selected Health Centres and staff housing units.

### 25 staff housing units and 10 Health Centres successfully electrified with solar power:

The solar power electrification involved installation of direct current electric power supply to selected Health centres and staff housing units to provide lighting and activate cold chain equipment in the affected health centres.

### 19 high frequency radios (KENWOOD TK80) installed at facilities:

A total of 19 high frequency radios (KENWOOD TK80) have been installed at centres selected by the Luapula Provincial Health Office. The Radios have wide distance coverage in excess of 800 kilometers.

### 8 Honda CT110 Motor Bikes have been provided to some Health facilities

A total of 8 Honda CT110 Motor Bikes have been provided to some Health Centres. Motor bikes play a crucial role in outreach activities.

### A Star Craft Engine Boat with a closed cabin purchased:

A Star Craft Engine Boat with a closed cabin, powered by 90 horse power Yamaha Engine has been purchased for Samfya DHMT. The boat will serve as an Ambulance to service the Health Centres on the Islands and swamps in Lake Bangweulu in Samfya District. The referral system in the district had faced immense transport challenges for years.

### 7 domestic vaccine fridges purchased and distributed to selected Health facilities:

The Luapula Project has provided seven (7) domestic vaccine fridges to selected Health Centres. Due to resource constraints, the fridges are without solar kits.

### Medical Equipment purchased and distributed:

Lack of medical equipment at most of the Health Centres continues to inhibit smooth and effective health service delivery system in the province. The following equipment which was greatly needed in the province has been provided in spite of the constrained budget:-

- |                              |   |    |
|------------------------------|---|----|
| • Theatre Lamps              | - | 2  |
| • Thermometers               | - | 20 |
| • Resuscitaires for Neonates | - | 2  |

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• Cesarean Section Sets	-	4
• Laparatomy Sets	-	4
• Delivery Sets	-	35

*Borehole drilled, 2 x 5000 litre water tanks and a submersible water pump purchased and installed at Mbereshi Mission Hospital:*

Mbereshi Mission Hospital in Kawambwa had been experiencing inadequate water supply, a situation which had resulted into blockage of the sewer system at the hospital. In order to address this problem, a borehole had to be drilled, 2 x 5000 litre water tanks were purchased together with a submersible water pump. The hospital has now got clean and safe water. This venture however was jointly undertaken by HSSP who provided 66% of the cost under the Luapula Project and with Zambia Prevention, Care and Treatment (ZPCT) providing 34% of the cost.

## 8 Sector Program Assistance (SPA)

The Zambia Sector Programme Assistance Agreement for Basic Health Care (SPA) between GRZ and USA through USAID came into force on 9 March 1999 to provide financial support to the GRZ contingent upon the GRZ meeting critical Performance Milestones. This financial support was provided in the form of US dollars to be auctioned through the foreign exchange auction system managed by the Bank of Zambia. The local currency (Kwacha) resources generated through this process were then made available as supplementary disbursement to support delivery of basic health services at the district level and below through the CBOH District Basket process. Further, the SPA Agreement performance requirements addressed difficulties in regularity, efficiency and accountability of GRZ financial flows to the Ministry of Health. The Performance Milestones mutually selected by the GRZ and USAID for the SPA Agreement contributed directly to improved achievement of USAID's intermediate results under its PHN strategic objective. Moreover, the Performance Milestones conformed to the Zambia MOH National Health Strategic Plan and the Ministry of Finance and National Planning (MOFNP) commitments to fund the MOH. USAID releases of SPA funds were tied to the successful completion of performance milestones.

The Agreement initially covered the period 1999-2004, with an Assistance Completion Date of September 30, 2004. This was later extended to 30 September 2005. A review of the SPA was conducted by USAID Washington in consultation with the GRZ which resulted in a no cost extension of the program to 2010.

In pursuit of its mandate under SWAPS and Health care Financing, HSSP was mandated to help GRZ document the relevant Milestones for FY2002, FY2003 and FY2004 so as to ensure more successful submissions to USAID. In the past this had been problematic.

The main activities included:

- Mobilization of data and documents required for the relevant Milestones in each financial year that is FY2002, FY2003 and FY2004.
- Physical follow-ups to mobilize data, documents and reports with major stakeholders, MOH/CBOH//and USAID. This involved follow-ups by telephone, Fax-mail, Emails and direct visits to provinces and Districts.
- Analysis of data/documentation and generation of reports there from.
- Generation of progress and status reports on regular basis.
- Upon receipt of invitation to submit from USAID, helped GRZ make the Milestone submissions for USAID's consideration and approval.
- Once approved and funds released by USAID to BOZ, make follow-ups with MOFNP and BOZ to ensure timely deposits of disbursed and auctioned funds into the CBOH basket account and USAID Trust Fund respectively

***The Applicable Milestones for FY 2002***

***Milestone 5.5.1 (\$1,000,000)***

Submit evidence to USAID, in form and substance satisfactory to USAID, that at least 33% of District Health Boards( 24-half of which set targets for 2001) reported improvements in access and utilization at the end of 2001; and at least 90% of the District Health Boards (65) established performance targets in their annual contracts for 2002 which can be monitored through the Health Management Information System(HMIS) and the Financial and Administrative Management Systems(FAMS).The performance targets relate to access, quality and utilization

***Documentation Required***

GRZ to provide USAID with a brief report assembling FY2001 performance data from HMIS and FAMS and compare with the targets set for the 48 districts which were previously submitted against performance Milestone 5.4.1. Note that half are to have met or exceeded their targets to comply with the Milestone. (Amended and restated Agreement, Annex 1, Section IV.B).

GRZ is to provide USAID with copies of the FY 2002 contracts between CBOH and the District Health Boards for the 65 Districts that show the annual indicators and targets for health performance.(Amended and Restated Agreement, Annex I, Section IVB). Please note only one complete set of contracts is required for the submission.

***Performance Area: Financial Reporting, Accountability and Management  
Performance Milestone 5.6.1(\$300,000)***

Submit evidence to USAID in form and substance satisfactory to USAID, that the CBOH has issued a comprehensive annual financial report which includes financial statements meeting standards for accountability and which contains an independent audit opinion from the GRZ Auditor General and/ or a private sector audit firm, in conformity with generally accepted accounting principles, international accounting standards or another comprehensive basis of accounting satisfactory to USAID.

Submit evidence to USAID in form and substance satisfactory to USAID, that the CBOH has issued a comprehensive annual report of its activities, The Annual report should contain in the annex a report of executed activities compared with planned activities (effectiveness of CBOH) and reports of the Health Sector Steering Committee, which contain data on resources and indicators of performance (efficiency of CBOH). Both of these reports should be finalized within 10 months of the end of that applicable GRZ fiscal year.

***Documentation Required***

GRZ to provide USAID with the CBOH Financial Report and CBOH Annual Report for the GRZ fiscal year 2002, both of which should have been finalized within 10 months of the end of the GRZ Fiscal year 2002. The Financial Report must contain an independent audit opinion from the GRZ Auditor General or private sector audit firm. Only one complete set of these documents are required for submission

***Milestone 5.6.2 (\$100,000)***

Grantee (GRZ) shall provide evidence that they have complied with Section 7 and Section 8 by maintaining a system of books, records and underlying documentation adequate to assume compliance with this Agreement and establishing auditing standards for such books and records

***Documentation Required***

There is no specific documentation requirement for this Milestone. However, USAID Representatives may inspect the GRZ books, records and documents related to the financial management of the SPA at any time. (Amended and restated Agreement, Annex i, Section).

***The Milestones Selected for FY2003 submission***

***Milestone 5.5.1 (\$1,000,000)***

Submit evidence to USAID, in form and substance satisfactory to USAID, that at least 45% of District Health Boards (32-half of those which set targets for 2002)) reported improvements in access and utilization at the end of 2002; and at least 95% of the district Health boards (68) established performance targets in their annual contracts for 2003 which can be monitored through the Health Monitoring Information System (HMIS) and the Financial and Administrative Management Systems (FAMS). The performance targets relate to access, quality and utilization

***Documentation Required***

GRZ to provide USAID with a brief report assembling FY2004 performance data from HMIS and FAMS and compare with the targets set for 64 districts which were previously set against performance Milestone 5.4.1. Note that half are to have met or exceeded their targets to comply with the Milestone. (Amended and Restated Agreement, Annex I, Section IV.B).

GRZ is to provide USAID with copies of the FY 2003 contracts between CBOH and the District Health Boards for the 68 Districts that show the annual indicators and targets for health performance.) Amended and Restated Agreement, Annex I, Section IV B). Please note only one complete set of contracts is required for the submission.

***Performance Area: Financial Reporting, Accountability and Management***

***Performance Milestone 5.6.1 (\$300,000)***

Submit evidence to USAID in form and substance satisfactory to USAID, that the CBOH has issued a comprehensive annual financial report which includes financial statements meeting standards for accountability and which contains an independent audit opinion from the GRZ Auditor General and or a private sector audit firm, on conformity with generally accepted accounting principles, international accounting standards or another comprehensive basis of accounting satisfactory to USAID.

Submit evidence to USAID in form and substance satisfactory to USAID, that the CBOH has issued a comprehensive annual report of its activities, The Annual report should contain in the annex a report of executed activities compared with planned activities (effectiveness of CBOH)

and reports of the Health Sector Steering Committee, which contain data on resources and indicators of performance (efficiency of CBOH).

Both of these reports should be finalized within 10 months of the end of that applicable GRZ fiscal year.

***Documentation required***

GRZ to provide USAID with the CBOH Financial Report and CBOH Annual Report for the GRZ fiscal year 2003, both of which should have been finalized within 10 months of the end of the GRZ Fiscal year 2003. The Financial Report must contain an independent audit opinion from the GRZ Auditor General or private sector audit firm. Only one complete set of these documents are required for submission

***Milestone 5.6.2 (\$100,000)***

Grantee (GRZ) shall provide evidence that they have complied with Section 7 and Section 8 by maintaining a system of books, records and underlying documentation adequate to assume compliance with this Agreement and establishing auditing standards for such books and records

***Documentation required***

There is no specific documentation requirement for this Milestone. However, USAID Representatives may inspect the GRZ books, records and documents related to the financial management of the SPA at any time. (Amended and restated Agreement, Annex i, Section).

***The Milestones selected for FY2004 submission***

***Milestone 5.5.1 (\$1,000,000)***

Submit evidence to USAID, in form and substance satisfactory to USAID, that at least 75% of District Health Boards (54) reported improvements in access and utilization at the end of 2004.

***Documentation Required***

GRZ to provide USAID with a brief report assembling FY 2004 performance data from HMIS and FAMS and compare with the targets from FY 2003 for the same indicators. Improvement must be demonstrated in at least half of the indicators assessed to consider that the district as a whole has shown improvement.

GRZ is to provide USAID with copies of the FY 2004 contracts between CBOH and the District Health Boards for the 72 Districts that show the annual indicators and targets for health performance. Please note only one complete set of contracts is required for the submission.

***Performance Area: Financial Reporting, Accountability and Management Performance  
Milestone 5.6.1 (\$300,000)***

Submit evidence to USAID in form and substance satisfactory to USAID, that the CBOH has issued a comprehensive annual financial report which includes financial statements meeting standards for accountability and which contains an independent audit opinion from the GRZ

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Auditor General and/ or a private sector audit firm, in conformity with generally accepted accounting principles, international accounting standards or another comprehensive basis of accounting satisfactory to USAID.

Submit evidence to USAID in form and substance satisfactory to USAID, that the CBOH has issued a comprehensive annual report of its activities, The Annual report should contain in the annex a report of executed activities compared with planned activities (effectiveness of CBOH) and reports of the Health Sector Steering Committee, which contain data on resources and indicators of performance (efficiency of CBOH).

Both of these reports should be finalized within 10 months of the end of that applicable GRZ fiscal year.

### ***Documentation required***

GRZ to provide USAID with the CBOH Financial Report and CBOH Annual Report for the GRZ fiscal year 2004, both of which should have been finalized within 10 months of the end of the GRZ Fiscal year 2004. The Financial Report must contain an independent audit opinion from the GRZ Auditor General or private sector audit firm. Only one complete set of these documents are required for submission

### ***Milestone 5.6.2 (\$100,000)***

Grantee (GRZ) shall provide evidence that they have complied with Section 7 and Section 8 by maintaining a system of books, records and underlying documentation adequate to assume compliance with this Agreement and establishing auditing standards for such books and records

## **8.1 Accomplishments**

As at 15 March 2005, a total of \$3,000,000 was pledged by USAID as being available to be accessed by GRZ before end of August 2005. Later, with the help of HSSP, on further examination of the total value of the remaining applicable Milestones, the total amount was found to be \$3,200,000.

The table below shows the achievements made (funds approved) from GRZ submissions made against each of the Milestones.

Milestone No.	5.5.1	5.6.1	5.6.2	Totals
<i>FY2002</i>	Not approved	\$300,000	\$100,000	\$ 400,000
<i>FY2003</i>	\$1,000,000	\$300,000	\$100,000	\$1,400,000
<i>FY2004</i>	\$1,000,000	\$300,000	\$100,000	\$1,400,000
<b>TOTALS</b>	<b>\$2,000,000</b>	<b>\$900,000</b>	<b>\$300,000</b>	<b>\$3,200,000</b>

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With the help of HSSP, GRZ submissions achieved a 100% success rate in terms of accessing all the available funds of \$ 3,200,000. As per the Agreement, HSSP contributed to ensuring that \$2,880,000 representing 90% and \$440,000 representing 10% were paid in full to, and received by GRZ(CBOH Basket account) and USAID (Trust fund account) respectively.

## 9 Knowledge Management

### 9.1 Overview

Knowledge Management (KM) consists of two components' research and program monitoring and evaluation. Responsibilities here included include coordinating research, program planning, reporting and documentation. However, this component has since been revised where only the project monitoring and evaluation was retained. This report will cover all the work done before and after the restructuring.

### 9.2 Research

To Support Zambia attain the Health Millennium Development Goals for reducing maternal and child mortality, malaria burden and HIV/AIDS prevalence, there is a great need for evidence based interventions. The research component of Health Services and Systems Program (HSSP) was committed to supporting the MoH/CBoH to strengthen research capacity i.e. mechanisms for -coordinating/disseminating health research at all levels and institutionalize research as an integral part of the health policy development and program implementation process.

The core activities here included supporting the creation of the National Research Ethics Committee; facilitate development of protocols for undertaking clinical research in traditional medicine and to support planning and organization of the 4<sup>th</sup> National Health Research Conference (NHRC).

#### 9.2.1 Goal and Annual Target

**Goal:** MOH research capacity is strengthened to manage and coordinate priority research activities that will influence health policy and programs

**Year 2 Target:** MOH conducting research according to set priorities

#### 9.2.2 Accomplishments

Research on "What Zambia Must Do to Reach the MDG on Child Health" was completed:

A study on "What Zambia Must Do to Reach the MDG on Child Health" was completed and disseminated on 12<sup>th</sup> May 2006. More than 75 participants attended the dissemination, including district and provincial health directors from regions with high and low under-five mortality. Other participants were from research institutions and cooperating partners. This research critically analyzed under five child mortality trends and survival interventions in Zambia. Among the key findings were that most deaths occur within the first few days of life; yet most interventions tend to focus in later days of the under five child. The report generated great interest among stakeholders. For HSSP the challenge now is to ensure that Child health interventions is to ensure that interventions made take into account this critical window of the new born child's life.

Progress on the Fourth National Health Research Conference:

Preparations for the Fourth National Health Research Conference (4<sup>th</sup> NHRC) have reached an advanced stage. A call for abstracts was advertised in print media and electronically sent to

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different partners. Short listing of submissions will be done in year 2. The MOH has pledged 150 million kwacha towards the conference. The shortfall will be met by various cooperating partners. The dates for the conference have been tentatively set for 7<sup>th</sup> to 8<sup>th</sup> December 2006. The research component has since been dropped under the revised program. HSSP will continue to support this activity e.g. providing the venue for the conference committee and some limited technical assistance where needed.

### Guidelines for conducting clinical research in traditional medicine were developed:

Guidelines for conducting clinical research in traditional medicine were developed working with the Tropical Diseases Research Center (TDRC) and other stakeholders. These guidelines are crucial in the wake of a recognition and appreciation of traditional medicines by Zambians.

### Technical Assistance on research provided to Lufwanyama DHMT:

Technical Assistance was provided to Lufwanyama DHMT to design and implement community operational research on reduction of neonatal mortality.

### District Action Plans reviewed:

A review of the of district health action plans revealed that research was not adequately planned for. Where it was conducted, the results were not systematically used to address given issues. Recommendations were made to support districts to prioritize research and use the findings to develop evidence based interventions.

### 9.3 Monitoring and Evaluation

HSSP monitoring and evaluation is conducted using routine reporting and periodic evaluation system. Core indicators have been developed for periodic evaluation while relying on the HMIS as a routine source of information as well as progress reports from technical teams.

Focus in the year being reported was on ensuring that the baseline survey was completed as well as strengthening the routine reporting system through supporting more focused planning, ensuring that reporting formats captured relevant information.

#### 9.3.1 Goal and Annual Target

**Goal:** Planning, monitoring, evaluation and timely reporting of project implementation

**Target:** Establish a functional monitoring and reporting system

#### 9.3.2 Accomplishments

*A data base, website and intranet were developed:*

A data base, website and intranet were developed and the contractors submitted these products to HSSP. The data base is primarily used for storage of information and generation of some reports. The intranet is aimed at improving access to project information by teams, especially the Clinical Care Specialists (CCSs) in their respective provincial localities. Effective utilization of the internet will happen when the CCSs are connected to the HSSP network. The website was registered with the domain name of [www.hssp.org.zm](http://www.hssp.org.zm) and is now accessible on the internet.

*HSSP baseline survey completed:*

The baseline report was finally completed. In view of the revised project the baseline data for the program is being updated in accordance with indicators obtaining. Most of the indicators however have been retained. Existing secondary data will be used as much as possible to provide baseline information for new indicators.

*Routine program planning and reporting conducted:*

Regarding coordination of routine project planning and reporting, the unit has coordinated development of the year 3 work plan based on the revised program description. The drafts are now being finalised. Quarterly review meetings have been conducted for all quarters and reports developed. More emphasis needs to be placed on development of success stories. Specialist staff is now required in the revised program to allocate 10% of their time and budget to routine monitoring for which they have developed plans. It is hoped that this will greatly strengthen implementation and reporting on results.

*Computer skills training for technical staff conducted:*

A training/update on computer skills was organized for technical staff to enhance their information management and reporting skills.