



# Health Services and Systems Program

## Year One Annual Report

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## Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CARE	Cooperative for Assistance and Relief Everywhere
CBA	Community Based Agent
CBO	Community Based Organization
CBoH	Central Board of Health
CCS	Clinical Care Specialists
CHAZ	Churches Health Association of Zambia
CHEWS	Community Health Waiver Scheme
CHW	Community Health Worker
DANIDA	Danish International Development Agency
DfID	Department for International Development
DHMT	District Health Management Team
EBA	Employer Based Agent
EPI	Expanded Programme of Immunization
FP	Family Planning
GAIN	Global Alliance for Improved Nutrition
GAVI	General Agreement on Vaccines Initiative
GNC	General Nursing Council
GRZ	Government of the Republic of Zambia
HC	Health Center
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSSP	Health Services and Systems Programme
ICT	Integrated Competency-based Training
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IRH	Integrated Reproductive Health
JHPIEGO	John Hopkins Program for International Education in Gynaecology and Obstetrics
JICA	Japan International Cooperation Agency
JSI	John Snow Incorporated
LMIS	Logistics Management Information Systems
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MoE	Ministry of Education
MoH	Ministry of Health
MoJ	Ministry of Justice
MOST	Micronutrient Operational Strategies and Technologies
MSH	Management Sciences for Health
MSL	Medical Stores Limited
NAC	National AIDS Council
NDP	National Drug Policy
NDPSC	National Drug Policy Steering Committee
NFNC	National Food and Nutrition Council
NGO	Non Governmental Organization

NIDs	National Immunisation Days
NMCC	National Malaria Control Centre
OPV	Oral Polio Vaccine
PA	Performance Assessment
PAC	Post Abortion Care
PHN	Population, Health and Nutrition Agency
PHO	Provincial Health Office
PHR	Partnership for Health Reform
PPAZ	Planned Parenthood Association of Zambia
PVU	Pharmaco Vigilance Unit
RBM	Roll Back Malaria
SIDA	Swedish International Development Organization
SWAp	Sector Wide Approach
TA	Technical Assistance
TI	Training Institutions
TOR	Terms of Reference
TOT	Training of Trainers
UN	United Nations
UNAIDS	United Nations AIDS Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
WHO	World Health Organization

## Child Health and Nutrition

### Overview, Goals and Objectives

Infant and under five mortality remain high in Zambia. The country has an infant mortality rate of 95/1000 with neonatal deaths contributing to two thirds of this. The under-five mortality rate is 168 per 1,000 live births (DHS 2001/2). 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 it's 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.

The nutrition programs focuses on strengthening the micronutrients control and other areas on nutrition such as Infant and Young Child Feeding. In the area of supplementation focus was on addressing the problems of low coverage of vitamin A supplementation, whilst in fortification strengthening the monitoring and providing support in the area of GAIN proposal for starting maize fortification in Zambia.

The integrated management of child hood illness has three components namely:

1. Improvement of health worker skills in management of the sick child
2. Support for health systems
3. Improvement of Household and Community Practices

Facility IMCI targets the sick child through the strengthening of components one and two while community IMCI (C-IMCI) focuses on the promotion of the 16 key family practices that are likely to have the greatest impact on child survival, growth and development. It is the key to provision of equity of access to cost effective and quality health care as close to the family as possible.

In the context of the Global Immunization Vision and Strategy (GIVS) which responds to the call of reaching the MDGs, the EPI programme in Zambia has adapted the global goals of maintaining coverage achievement of 80% of districts with 80% full immunization coverage of children under one year; 2/3 reduction of global childhood mortality and morbidity due to Vaccine Preventable Diseases (VPDs), (compared to 2000 levels); New vaccines (DPT-HepB +Hib) to reach same coverage within 5 years; Access to vaccines of assured quality and capacity for case-based surveillance.

The major focus for HSSP's technical assistance during the first year under review in EPI was to support the country with the development of a five year plan, utilize proven strategies for the catch up and increasing immunization coverage including Private Practice involvement, support implementation of RED strategy, contribute required documentation for the polio free certification process, accelerating the achievement of Maternal Neonatal disease eradication, measles control, and building capacities of health workers to the introduction of new vaccines and relevant technologies and tools. Key achievements are described below:

In 2004 the Health services and systems program (HSSP) a USAID funded project started working with the MoH to assist the government of Zambia through central board of health. One of the areas of concern was the health of children. There was need to maintain a healthy child and give curative services to those who are sick. In a harmonious relationship with all the nine provincial health offices (PHOs) and districts it was identified that technical assistance and in some cases financial assistance was to be provided to enhance health of children.

### **General objective**

The HSSP Child Health and Nutrition program support will focus at providing TA for the country to attain its objective for reducing child morbidity/mortality and HIV/AIDS prevalence.

### **Goals**

- Support the MOH/CBoH to finalize the child health policy.
- Through the established district planning cycle provide technical assistance to MoH to strengthen district IMCI comprehensive planning and implementation.
- Work with MOH/CBOH to promote district ownership of IMCI
- Strengthen CBOH capacities to provide comprehensive guidelines, training materials, and tools to DHMTs to implement all three IMCI components
- Provide TA and financial assistance to MoH/PHO to scale-up the IMCI implementation by health worker training both as in and pre service and promote priority six key family and community practices that are vital for optimal child survival, growth and development in some selected districts
- Provide TA to PHOs during Technical Supportive Supervision with emphasis on skills observation in regards to CHN.
- To provide TA to MOH/CBOH in the introduction of Hearth/Positive Deviance (H/PD), in collaboration with Save the Children.
- To promote, strengthen and sustain existing key family and community practices that are vital for optimal child survival, growth and development.
  
- Provide TA to National food and nutrition commission (NFNC) in the development and finalization of the nutrition strategic plan.

- Together with MOH/NFNC facilitate district ownership on child health week (CHWk) through the inclusion of planning for child health week planning in the district annual planning guidelines.
- Work with Fortification Task Force and stakeholders and promote quality fortification of sugar.
- Provide TA to NFNC/BU to develop proposal on fortification of oil, milk and weaning foods.
- Support NFNC and stakeholders on promotion of yellow fleshed potato growing.
- Provide TA to NFNC to develop an infant and young child feeding strategic plan.
- To work with the UCI secretariat in strengthening their coordination and monitoring roles in EPI activities.
- In collaboration with other partners, support MOH/CBOH to introduce new vaccines.
- Support MOH/CBOH to conduct a comprehensive EPI programme review and develop a multi-year plan (2006 – 2010) to guide the implementation of EPI activities.
- Work with respective PHOs and districts to increase the proportion of districts with 80% full immunization coverage for children under one year old.
- To support CBOH/MOH in the implementation of accelerated disease control and elimination strategies to achieve polio-free status.

### **General strategy**

The HSSP strategy is to work with MoH/CBoH, PHOs and selected high risk DHMTs to strengthen the health systems for continuously assuring and ensuring the provision of value added 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 that have the best prospects of supporting increased coverage and integration of health services.

In addition, investments are also being directed towards the developing and testing of sustainable approaches for scale up of services to all the deserving children. To this end, the Child Health team will focus on high-impact activities to improve coverage and quality of Child Health and Nutrition services as well as integration and support for related HIV/AIDS services.

### **Specific Strategies**

To strengthen the programme management of the micronutrients control programme a strategic plan with partners in the sector was developed to provide guidance on the priority areas that the country will be addressing. To operationalize the plan the components of the plan were further developed which included the Information Education and Communication (IEC) and a monitoring and evaluation plan.

In an effort to address the quality of services provided for nutrition a draft document defining the minimum package of care. The package is aimed at providing guidance to

districts on the key areas that districts need to implement to address the existing nutrition problems in the country.

To increase the coverage of nutrition programmes the main strategy was to provide input in the provincial planning launch of the health sector. This was to ensure relevant backstopping required was provided to the provincial office.

For the broader nutrition issues that require to be addressed, the national development plan to ensure the nutrition programmes is reflected adequately. Support was provided to NFNC as the coordinating body for nutrition programmes in Zambia, to facilitate the development of nutrition as a cross-cutting issue in the national development plan.

Support in the printing of the National Food and Nutrition Policy as a means of hastening the process of providing a policy framework for nutrition programmes to be implemented.

Support in the compilation and dissemination of the Nutrition profiles to the advocacy working group to update the nutrition profiles presentation as a means of improving ways of resource mobilization and adequate nutrition inclusion planning in different sectors.

One strategy used to address coverage included updating of the Child Health Week manual. The focus in updating the manual was to ensure that adequate information was provided for improving service provision. It also addressed weaknesses and technical shortfalls identified during the planning and implementation of CHWk.

A review meeting was held 12<sup>th</sup> – 15<sup>th</sup> September, 2005 in Lusaka as part of the process of continuing to institutionalize Child Health Week and improving capacity of implementing Child Health Week. Key issues addressed were the major constraints in improving coverage and successful implementation.

Focus group discussions were conducted with health staff, mothers/caretakers and community health workers during the orientation for CHWk and during CHWk itself. The purpose of the focus groups was to identify from their perception what factors could be associated with the declining coverage. The information collected was used to complement data obtained from the monitoring reports and district CHWk reports.

In the area of supplementation for 6- 59 months, in terms of improving monitoring provinces and districts continued to work with national level in mentoring of both rounds of CHWk (December 2004 and July 2005). Furthermore the monitoring system was discussed with the national monitoring tools were revised and adapted for district level during the CHWk review meeting.

Participation in the revision of the Childs Clinic Card ensured that the provisions for recording of the under five and postnatal supplementation are adequately captured at different time points. This will assist in improving the capturing of routine supplementation of under fives and maternal postnatal supplementation coverage.

The focus of the Fortification program is to improve the quality of the fortified sugar of the fortified sugar through provision of TA to the food industry, increase the coverage on the consumption of fortified foods through fortifying commercially produced Maize meal with a

multi-mix ( a combination of Vitamins and Minerals) and exploring the possibility of fortifying other foods e.g. milk, Cooking oil and some weaning foods.

The other strategies include working with NFNC in planning for MTEF and including a Nutrition Chapter in the National Development Plan.

The strategies for implementation of community IMCI include; Collaboration with the Ministry of Health and other stakeholders, participation in weekly child health working group meetings, provision of technical supportive supervision to PHOs and districts, participation in the Provincial Inter-district action planning meetings, conducting capacity building of PHO and district staff on C-IMCI implementation, and coordinating of activities to develop and support systems.

Strategies to increase coverage, quality and strengthen systems for immunization services were as follows:

- Strengthening routine and outreach immunization services in ten high risk districts through technical support supervision.
- Increasing community participation in reaching un-immunized children and defaulter tracing through the introduction and expansion of RED strategy.
- Integration of other child health related activities to strengthen routine and catch up mini campaigns such as Child Health Week activities.
- Establishment of electronic vaccine management tools in all the provinces to monitor vaccine use and wastage rates.

## **Accomplishments**

### General Child health

During the first year of HSSP existence, support was provided to MOH to develop and finalize the child health policy. Work towards finalization of the Child Health Policy has advanced and a third draft of the policy document has been produced and circulated to all the stake holders for comments. The child health policy will provide policy guidelines for the implementation of child health activities by various stakeholders. It is hoped that a consensus on the child health policy will be reached from all stake holders during HSSP second year.

### **Nutrition**

Following the development of the Micronutrients Strategic Plan, a consensus meeting was held with stakeholders to review the draft. The plan focuses on integrating different interventions across different sectors in order to holistically address micronutrient deficiency control. This strategy of planning with sectors beyond health highlighted other key areas that are addressing micronutrients control. A good experience was the school health and nutrition programme being conducted by the Ministry of Education which has had major strides in micronutrients control.

As a step in the development of the implementation of the IEC component of the Micronutrients plan a formative research and stakeholder workshop were planned for the

year 2 of HSSP work plan. However with additional funds made available through the MOST project through ISTI these two activities were moved to year 1 and conducted in August and September 2005 respectively. The formative research was conducted to gather information on the gaps in developing the IEC operational strategy. Following this, a stakeholder workshop was held with key partners working in the area of IEC and micronutrients. A framework to address key behavior changes is being refined and the first draft will be ready by the end of September.

As a part of the year two planned activities development of an integrated Nutrition monitoring system was planned. This system is aimed at integrating the various data sources in Health, Education and Agriculture on key interventions in nutrition. This is in an effort to make information available for decision-making. Similarly, with additional funds provided from MOST project through ISTI.

In response to the recognition of the inadequate capacities in districts to plan for nutrition in the districts, a draft guide for planning in the nutrition minimum package of care was drafted. It is planned that the reference guide will provide some technical back up to districts during the preparation of their annual plans. This is a strategy to strengthen district capacity to plan and implement nutrition interventions.

Participation of the district and hospital staff enriched the process of development of the document. A major observation from this workshop was the need to provide more support hospital Nutritionists with dietetic protocols as a lot of emphasis had been played on the public health. A key issue emerging from the workshop included the need for complementary. Nutrition reference guidelines for health workers and Nutritionists to use in implementing nutrition programmes. A refined draft is being worked on to facilitate further revision. The main focus for the coming year development of operationalization of strategies

The programme succeeded in achieving all of the major activities planned for the year in the area of supplementation. The activities set out included supporting low performing districts during the two rounds (December 2004 and July 2005) of CHWk, updating of the Child Health Week manual, hosting of a review meeting and provincial orientation of new CHWk manual.

Integration of orientation of CHWk with introduction of the New Vaccine, Reach Every District (RED) strategy and the revised Children's Clinic Card, illustrated the value of maximizing use of resources. The provincial orientations were supported largely by the GAVI reward money for extra children immunized.

Unplanned activities that were embarked on as a strategy included participation in the review of the Children's Clinic Card and conducting of focus group discussions. The focus group discussions showed the value of addressing perceptions of the health workers and mothers that may be affecting coverage.

HSSP provided technical assistance to the hosting of an inter-country regional meeting hosted by UNICEF. Eleven African countries attended the meeting of which Zambia, was the country with longest experience in implementing country. The meeting highlighted the

issues that most countries are struggling with such as postnatal supplementation, inadequate staffing in health facilities.

The main focus for the next year will be focussing on ensuring CHWk planning is strengthened in the planning cycle as a key strategy of institutionalisation. The monitoring aspects will also be focussed to strengthen data management of CHWk reporting.

CHWk currently does not face any gender limitations in getting preventive services during CHWk. Minor limitations have been experienced during the December round of CHWk in the farming communities. This is as a result of where their time use is strained by the roles they play of participating in farming and looking after children. Mothers/caretakers in certain instances do not come for CHWk in preference to the farming activities. Ways of addressing this has been an effort to move the dates of CHWk from December to November to allow them to focus on farming activities in December when the rainy season that coincides with planting season although there are variations.

The mandatory legislation on Maize Meal fortification that was planned in anticipation of the commencement of the maize meal fortification program was not operationalized. However the maize meal fortification program could not begin during the year under review as the proposal submitted to the Global Alliance for Improved Nutrition (GAIN) was still being assessed. Much effort was spent on reviewing the proposal i.e. reviewing the budget, re-sequencing activities and consulting the millers. The result of this effort is that the proposal was approved by GAIN and the Grant Agreement will be signed soon. 32 Commercial Millers will benefit from this grant.

Lusaka millers and some NGOs were met to discuss the Maize Meal fortification programme. It was agreed during the meeting that fortification of commercially produced Maize Meal should go ahead and that there is need to do more feasibility studies on the fortification of Maize Meal produced by hammer mills. The result of these meetings was an agreement that there should be a mandatory legislation to level the playing field.

Provide TA to Zambia Sugar on the installation of appropriate mixing equipment; A consultant from Canada was hired to Assist the Zambia Sugar Plc to identify the suitable mixing system in the fortification of Sugar. This was in response to report by Oscar Monzon and Phillip Makhumula which indicated that the Sugar from Zambia Sugar Plc was not uniformly mixed with the fortificant ( Vitamin A). The consultant recommended some modification to the current packaging system so that a mixer could be installed. However the modification requires a huge capital outlay hence the recommendation will not be implemented immediately. The Zambia Sugar Company is exploring short term measures to improve the mixing of the sugar and the fortificant.

Food and Drug Control Laboratory was assisted through the provision of an expert to Train laboratory staff in the new and cost effective methods of micronutrients analysis for five days at the Food and Drugs Control Laboratory in Lusaka. 15 laboratory Technicians from UNZA, FDCL, ZABS and NISIR were trained. This will form a core group that will be dealing with quality issues in the fortified foods. The training of the laboratory technicians was a deviation from the original idea of engaging a consultant to review the current methodologies being used in the laboratories and recommend improved methods. The

taskforce decided instead to send two people to South Africa to learn the new methods and thereafter return to train others in Zambia. This was thought to be cheaper and more effective. The training was sponsored by MOST. There will be a follow up training for Milling and Sugar Industry Staff. The training will contribute to the improvement in the quality control systems of the fortified foods.

Development of procedures of fortification surveillance at boarder points was not conducted as per plan. The objective was amended so that the focus is on developing a monitoring system for all micronutrient program and in the anticipation of the maize meal fortification tease out a program to monitor the maize meal fortification. To this effect a four day Meeting on the development of the Monitoring and Evaluation framework for Maize Meal Fortification was conducted in Lusaka. This was organized by the National Food and Nutrition Commission, sponsored by GAIN and Facilitated by CDC. 14 participants from FDCL, NISIR, National Millers Association, NFNC and National Milling attended the workshop. The meeting developed a frame work on which the Monitoring and Evaluation system for the Maize Meal fortification will be based. The M and E will address the issues of Quality Control and Assurance in the fortification of maize meal.

### ***Food based.***

This is not a fortification activity is one of the ways to increase the intake of micronutrients. HSSP is assisting NFNC and other stake holders to promote some of the foods currently a stakeholders analysis on the production and use of Yellow Fleshed Sweet Potatoes is currently being conducted by a consultant from UNZA. This is response to the agreement reached at the strategic planning meeting to establish what is being done and by who on the yellow fleshed potato. Further activities will be developed from the recommendations made by the consultant. The process will end at the of September. The Consultant has been sponsored by HSSP using funds from MOST.

The activity to support CBOH orient Health inspectors in prosecution has been postponed until the legislation on Maize meal fortification has been made mandatory. The mandatory legislation will come into effect after millers start the fortification

Provide TA to NFNC to conduct feasibility study on oil, milk and weaning foods; this activity was supposed to be conducted with the assistance of the fortification experts from ISTI Inc. However it could not be conducted during the year under review as the experts were not available due other commitments in other countries. This was rescheduled to the 1<sup>st</sup> quarter of year 2 ( 2005/2006)

### **Key Results in Nutrition**

- Micro nutrient strategic plan developed.
- Workshop on micro nutrient IEC and formative research held.
- A draft guide for planning in the nutrition minimum package of care developed.
- A number of districts with low Vitamin A coverage supported during CHWk

- The CHWk orientation manual updated and piloted in the June CHWk round.
- CHWK planning included in the district annual planning guide.
- The Zambian GAIN proposal on maize fortification accepted by GAIN foundation.
- 14 participants from FDCL, NISIR, National Millers Association, NFNC and National Milling attended the workshop on M/E of maize fortification.
- 15 laboratory Technicians from UNZA, FDCL, ZABS and NISIR were trained new and cost effective methods of micro nutrient analysis
- TA provided to Zambia sugar on installation of proper mixers.
- 1 consultant employed to study the availability of yellow fleshed potato in the country.

### **Facility IMCI**

Facility IMCI focuses on improvement of health worker skills through training in case management of the sick child and through strengthening health systems that promote effective care of children. The target diseases in IMCI are malaria, Diarrhoea, acute respiratory infections, malnutrition, measles and HIV/AIDS which account for over 70% of under five mortality and morbidity. 38 out of 72 districts in the country have been implementing facility IMCI.

HSSP during the year under review endeavored to ensure that PHOs and DHMTs make comprehensive IMCI a regular part of their plans in all districts. This was carried out through strengthening IMCI in the child health technical working group, ensuring that roles and responsibilities of the MOH and child health unit are clearly defined. Through HSSP support, capacity was built at national level through the training of the Child Health specialist in IMCI. This has since resulted in better articulation of IMCI issues in the technical working group.

To promote a comprehensive IMCI implementation by the districts the child health team supported MoH to finalize IMCI orientation and planning guidelines for the provinces and districts. These guidelines were used to re-orient all the PHOs in IMCI. The HSSP child health team supported MOH in the orientation of Western, Lusaka and Eastern provincial health offices as well as Petauke and Kaoma districts using the same guidelines. IMCI orientation and preliminary visit is the first step in the implementation of comprehensive IMCI for the districts. The MOH National level in collaboration with the PHOs and other partners must conduct these visits to mark the beginning of IMCI implementation. The goal of the visit is to provide information and guidance on the implementation of both Facility and Community IMCI. A preliminary visit is part of the process in qualifying a district to the list of IMCI implementing.

In addition, the process to orient the entire non-IMCI implementing districts has started with a vision of having all 72 districts oriented by 2005. The child health team provided TA during the orientation of the districts in Southern and Western provinces in the first phase of the exercise. The districts visited were Lukulu, Sesheke, Shangombo and Kalabo in Western province and Monze Siavonga, Namwala Itezhi-tezhi and Nyimba in Southern province. It is hoped that during the first quarter of year two of HSSP the activity will be scaled up to the rest of provinces in line with the IMCI strategic plan. There are 11 districts

still to be oriented. These are Kapiri Mposhi and Mumbwa in central province, Chingola, Masaiti and Mpongwe in Copperbelt province, Luangwa in Lusaka province, Nakonde in Northern province and Chavuma, Kabompo, Mufumbwe and Zambezi in North Western province. The orientation visits were successful in stimulating enthusiasm by the PHOs/DHMTs to train health worker staff in IMCI and to provide support for IMCI activities during the bi annual technical supportive supervisory (TSS) visits. The visits also provided guidance on the most cost-effective ways of conducting IMCI health worker training and documentation of IMCI activities.

To improve health worker performance in IMCI, skills observation was conducted during TSS in Luapula province. The Luapula province PHO asked for TA from HSSP during their TSS and observing the assistance that was rendered the PHD has this to say,

*” The TA that the HSSP child health team has provided was eye opening for the provincial team and went a long way in motivating health workers that were observed, I feel in future TA should be extended to other technical areas such as reproductive health”.*

Skills observation was also conducted during a support supervisory visit that was done in Kaoma district. This activity was done in collaboration with Kaoma DHMT in order to build capacity in support supervisory skills.

During the year under review capacity building in IMCI for tutors and PHO clinical care specialists was done through 6- day IMCI abridged courses. Two such courses were conducted including one Training of Trainers. Overall 42 participants were trained. Among them were 14 nurse tutors, 1 nurse from the GNC, 12 medical doctors, 3 clinical care specialists, 5 nurse in-charges and 1 district director of health. These are expected to provide onsite technical support to IMCI in their institutions. A regular 11 day health worker IMCI training was co sponsored by Nyimba, Chipata, Petauke DHMTs with technical and some financial support from HSSP child health team. A total of 27 health workers were trained. This was a mile stone in districts taking the initiative of pooling resources to conduct IMCI health worker training as a cost saving measure. During this training revised materials which have HIV/AIDs and the new malaria treatment guidelines were used. The exercise work book was also used as cost saving measure so that the modules can be re-used.

To promote the scale up of IMCI health worker training by the districts TA was provided to MoH/CBoH in developing a proposal that will encourage all stakeholders in IMCI to contribute to a pool of funds that will be used to bulk print IMCI training materials. If training materials are present it is envisaged that more districts will engage in training their health workers since one of the components that makes IMCI training expensive would have been taken care off. There is evidence of some positive response with partners showing interest in principal. It is hoped that in the first quarter HSSP will support a partner meeting to review this initiative. To spearhead this process of providing training materials to the districts, 120 sets of IMCI training modules as well as wall charts have been printed and await requests from the deserving districts. The Petauke, Nyimba and Chipata district training was the first to benefit from this pool of training materials.

In the same spirit of promoting the scale up of IMCI, the child health team provided TA during the provincial planning sessions for Southern, Western, Eastern, and Luapula provinces. Southern and Western provinces specifically requested for presentations on IMCI. The need to plan and budget for all the components of IMCI within the basket was

emphasized. This has paid off as already there is evidence of an increase of district plans with IMCI activities. All district plans in Luapula province have included various IMCI activities as well as most districts in Western province.

The process of implementation of the IMCI curriculum in the training institutions has been a challenge. No consensus has yet been reached on the mode of training and the materials to be used. During the last year a meeting was held with representatives of various training institutions to review the current status of implementation of IMCI in these schools. A road map has been drawn to map the way forward in the implementation process and the child health team will continue to support the process in the coming year.

The child health team also provided TA to MOH/NFNC in the editing of the Child Health Week orientation manuals to include IMCI. Child health Week provides an opportunity to strengthen the use of IMCI guidelines in the management of the sick child. The revised manual with the monitoring tools were piloted in Luapula province initially. With the feedback the tools will be revised before scaling up to all the provinces in the next Child Health Week

Through all the interactions with the PHOs and the DHMTs, the child health team used every opportunity to advocate for improved communication and referral systems. Positive results following this have included USAID support to Luapula province in purchasing of radio communication equipment for the selected health centres and some ambulance radios. Lukulu districts is sourcing for support for repair of radios from Zambia Flying Doctor Service, and Sesheke district is planning to buy cell phones for the health centres which have no radios but are in areas which are on Celtel connection as a short term measure.

### **Key Results in IMCI**

- Renewed focus on IMCI in the child health technical working group
- MOH/POH/DHMTs roles and responsibilities regarding IMCI defined
- Comprehensive IMCI orientation and planning guidelines finalized and operationalised
- All provincial offices oriented in IMCI strategy
- All districts in Luapula Province and most districts in Western province have incorporated IMCI activities in 2006 action plans
- 10 more non IMCI implementing districts oriented in the strategy
- Proposal for resource mobilization for the bulk printing of IMCI training materials written ,endorsed by the director general CBOH and disseminated to partners
- 120 sets of revised IMCI training materials with HIV/AIDs and the new malaria treatment guidelines printed and some of the materials used to train 27 health workers.
- Capacity built in 4 Luapula provincial and 1 Kaoma DHMT technical officers in skills for supervising trained health worker trained in IMCI

- 3 clinical care specialists, 14 nurse tutors, 12 medical doctors, 1 nurse from GNC and 1 district director of Health trained in the abridged IMCI course, and 9 trained in IMCI facilitator skills.
- Health centre radios and ambulance radios purchased for Luapula province through USAID support,
- Districts showing initiative by renewed focus on including repairs/purchase of means of communication eg. radios or cell phones in the 2006 action plans
- Child health week training manuals revised to include IMCI and piloted in Luapula province
- Roadmap developed for review of status of pre-service IMCI implementation in Zambia

### **Community IMCI**

The IMCI strategy was introduced in Zambia in 1996. Since then MoH and partners have been implementing the first two components which are health worker training and systems support. The third component which focuses on community and family practices was introduced in 1998 and has not progressed in implementation as the other components. It has been implemented in the DHMT by different NGOs which were not enlisted at the central level. A situational analysis conducted identified that in the 31 districts that were visited only 23 DHMTs were implementing six of the 16 key community and family practices that promote child survival. To promote the scale up of C-IMCI, the HSSP child health team provided TA to MoH to introduce and expand community IMCI. To achieve this HSSP started by holding of a workshop at which, consensus was reached on who leads implementation of C- IMCI.

The Child Health Working Group has since then been putting more emphasis C-IMCI implementation than it was previously. HSSP in collaboration with other partners provided technical assistance to MOH on the finalization of the national C-IMCI strategic plan document. The final draft Community IMCI strategic plan was completed and submitted to the MOH. The community IMCI strategic document will help the Provincial Health Offices (PHOs) and District Health Management Teams (DHMTs) in facilitating the implementation of community IMCI.

The Community Health Worker training manuals are among the tools recommended for capacity building of C-IMCI. HSSP provided technical assistance to MOH for updating of the Community Health Worker training manuals with the key family practices. The materials were updated and have since been printed and distributed to all the provinces. So far two provinces have used the materials to train trainers of CHW. WHO provided US \$ 10,000 for the printing of the 1000 edited CHW handbooks and 300 training guides. UNICEF is printing additional copies worth about US\$ 40,000. The MOH has also allocated ZMK 60 million for additional printing. JICA has printed the documents for some Health Centres in Lusaka. PLAN International has also pledged to print for Mazabuka, Chadiza, Chibombo and Mansa districts. Other collaborating partners who have pledged more additional funds are NMCC (Global Funds) and CARE International. Availability of upgraded training materials will facilitate capacity building of community resource persons for C-IMCI.

During the year under review efforts were directed towards the development of the child health communication strategy. For a long time a strategy on how child health issues were to be communicated was missing

WHO funded a training course for the National Community IMCI facilitators whose objective is to empower the PHOs, DHMTs and community levels to gather and analyze information about ongoing community activities and enable them develop C-IMCI operational plans and share experiences, resources and expertise. 14 participants from the 9 provinces and some collaborating partners from WHO, JICA, HSSP, CARE International and NFNC attended the course. This input will contribute to the scaling-up of C-IMCI. This activity was not planned by HSSP.

Luapula and Western provinces have been identified as priority areas for scaling-up of community IMCI due the high under-5 mortality rate. In order support PHOs in district level training of Community based agents for child health, HSSP conducted training of 22 and 23 Provincial trainers of community Child Health Promoters in Luapula and Western provinces respectively. The training included the Clinical Care Specialists and DHMT representatives for both provinces. Three trainers were drawn from every district (7 in Luapula and 7 in Western province). The provincial trainers will be conducting training of community child health promoters that will promote the key family practices and community based growth monitoring programs.

In additional to the basket funded community action plans and budget, more resources were mobilised for C-IMCI implementation. ZMK 1 billion kwacha more was allocated for C-IMCI to four provinces (Luapula, Western, Northern and Central provinces) and 24 districts (six from each province). The four PHOs were allocated a sum of ZMK 80,000,000 each for supervision of community IMCI implementation; purchase of bicycles for CHWs and the training of trainers of CHWs. Each of the 24 selected districts received ZMK 24,498,200 for the training of CHWs. All the four provinces have already trained a total of 94 trainers of CHWs. These trainers will be using the recent upgraded materials to train their CHWs. Some districts are also using the same resources to train the Child Health Promoters. The trainings are currently being coordinated by the DHMTs in the 24 districts.

The National Malaria Control Centre (NMCC) will soon introduce the use of Artemisin Combination Therapy (Coartem) for community case management of Malaria. Nine districts have selected to participate in the first phase of implementation using the global funds. HSSP in collaboration with NMCC conducted the orientation of the Copperbelt PHO, Lukulu, Zambezi and Chavuma DHMTs. Implementation is awaiting availability of global funds.

Save the Children finally visited HSSP last August to plan for implementation of the three approaches to C-IMCI i.e. Community Case Management (CCM), Hearth/Positive Deviance (H/PD) and Partnership Defined Quality. During the meeting Save the Children finalized the plan to provide STTA to HSSP and MOH on the implementation of Hearth/Positive Deviance (H/PD). Positive Deviance Inquiry will be conducted in the next quarter as it is the first step to H/PD.

HSSP provided technical supportive supervision with emphasis on C-IMCI to Luapula Province PHO; and the districts of Mwense, Kawambwa, Nchelenge and Chiengwe.

### **Key Results in C-IMCI**

- Consensus reached on goals, roles and responsibilities.
- C-IMCI TWG re-constituted and TOR developed.
- Final draft C-IMCI strategic plan in place.
- Community health worker manuals revised and updated to include 16 key family practices.
- Provided leadership in the printing and distribution of C-IMCI materials.
- Contributed to the development of child health communication strategy. The third draft is in place.
- 94 health workers trained as trainers for CHWs.

### **Expanded Program on Immunization**

The Expanded Programme on Immunization aims at preventing morbidity and mortality against the common childhood vaccine preventable diseases namely; Tuberculosis, Diphtheria, Pertussis, Neonatal Tetanus, Poliomyelitis and Measles. Recently more diseases have been added to the list of target vaccine preventable diseases and include Haemophilus Influenza type B and Hepatitis B.

HSSP's technical assistance contributed to the implementation of a comprehensive review of the Immunization programme from which findings and recommendations have been used as the basis to develop a Multi-Year Plan that will be implemented from 2006–2010. The multi year plan will be used as a basis for resource mobilization and for monitoring implementation of EPI program. The next step in operationalizing the multi year plan is to support MOH in disseminating the plan to stakeholders for resource mobilization.

A total of 1300 frontline health workers, 216 DHMT supervisors and 18 Provincial team members underwent training in pentavalent vaccines, RED strategy, vaccine management and new technologies

With the high number of partners for immunization (WHO, UNICEF, USAID/HSSP/HCP, JICA, Rotary International, DANIDA and CHAZ), strengthening the coordination role and establishing a coordination mechanism by the UCI secretariat becomes instrumental for the implementation of the immunization programme in Zambia. It is planned that the quality of provision immunization services will be improved.

The high profiled Inter-Agency Coordinating Committee (ICC) has provided good leadership in strengthening partnerships for immunization activities in the country resulting in increased Government financial contribution towards Vaccine Independence Initiative

(VII) which has progressed from 4% in 2002 to 78% in 2005 on the purchase of traditional antigens.

The availability of vaccines and the strengthened cold system has resulted in the attainment of 91% immunization coverage for DPT3 vaccine in the year 2004. At policy level the role of the Interagency Coordinating Committee (ICC) is critical. It is at these levels where HSSP's role is critical in ensuring that reports, communication and meetings are timely accomplished by the child health team. During the period under review ten ICC meetings were timely held with timely prepared minutes with respective reports.

To improve immunization coverage, the Reaching Every District/ Child (RED/C) strategy was introduced in 10 pilot districts in 2003. This has contributed to the high coverage as the strategy aims at reaching the un-immunized children who have been left out in the routine system. HSSP has contributed in the implementation of RED strategy through the provision of TA to MoH in training and supervision. HSSP's TA has contributed to the preparation of plans to expand RED strategy to 14 additional districts in the coming year using the GAVI award funds. Some of the preparations include a series of trainings that have been conducted to update frontline health workers in new technological changes in EPI. During the year under review the child health team in conjunction with the HMIS conducted a desk review and 15 districts with immunization coverage below 60% were identified for more focused technical assistance. The districts were in four provinces namely Northern, Luapula, Western and Eastern. HSSP's technical assistance to MoH utilized CHWk and RED strategies increase immunization coverage. Application of the RED strategy resulted in reduction in the number of un-immunized children from the initial 24,000 in 2003 to 16,000 in 2005. GAVI reward fund which stipulates that a country gets 20USD for every extra child immunized above the set target resulted in Zambia being rewarded \$2, 165million and \$700,000 in April and August 2005 respectively for the extra children immunized above the targeted number.

During the period under review a system for monitoring vaccine use and wastage rates in order to sustain the EPI program was introduced through WHO.

Zambia has committed itself to disease eradication/ elimination by adding to the list of those diseases to be eliminated which includes tetanus. This has been done through the implementation of Maternal Neonatal Tetanus campaigns. Maternal Neonatal Tetanus Elimination (MNTE) desk review was conducted in 2003 and 2005 revealed reduction in the number of high risk districts for maternal neonatal tetanus from 13 in 2003 to 5 in 2005. HSSP technical assistance resulted in a successful implementation of MNTE campaign in the 5 high risk districts (Sesheke, Chama, Luwingu, Mwense and Milenge) combined with CHWk activities. These campaigns have been successfully implemented in 5 districts through good partnership between stakeholders including HSSP, JICA, UNICEF, WHO, Central Board of Health and the Ministry of Health. The following were some of the results during the December 2004 round: Tetanus Toxoid for pregnant women – 98%, Vitamin A administered in all the 72 districts during the integrated Child Health Week intervention with a coverage rate of 72% for children aged between 6-59 months

Zambia has reached polio certification levels for achieving high AFP surveillance indicators of above 2 cases/ 100,000 children aged below 15 years while the stool adequacy was at 92%. These indicators are in conformity with the global established standards. Validation

and submission of Annual Progress reports on Polio Eradication Initiative (PEI) to the African Regional Certification Commission (ARCC) has been completed. HSSP contributed to this process by providing TA during attendance of the polio expert committee and the completion of required documentation on field Vaccine Preventable Disease outbreak response reports. This achievement of Zambia reaching the polio certification levels is as a result of the country recording no indigenous polio cases due to wild polio virus not being detected for over the past ten years. During the year under review Wild Polio Virus outbreak has been reported in eastern part of Angola that borders Kalabo, Shangombo and Lukulu in Western province. For this reason existence and strengthened certification level case based Acute Flaccid Paralysis (AFP) surveillance system will be critical. These reported Wild Polio Virus in Angola calls for Zambia to provide financial and more focused technical assistance to districts in Western province such as Kalabo, Lukulu and Shangombo. This is for the purposes of increased routine coverage of polio and heightened AFP surveillance. These districts face challenges that include critical human resource shortages, inadequate transport and geographical terrain which negatively affect the life span of vehicles resulting in poor access to communities and low utilization of services.

#### **Key Results in EPI**

- Comprehensive EPI review completed
- EPI Multi year plan developed
- 1300 front line health workers, 216 DHMT supervisors and 18 provincial health management teams trained in the introduction of new vaccines, RED strategy, and new technologies in EPI.
- Government contribution on traditional vaccines increased from 4% in 2002 to 78% in 2005
- Number of districts with full immunization coverage of 80% and above for children under one increased from 33 in fourth quarter 2004 to 37 in first quarter 2005.
- 15 poor performing districts identified from the 2004 immunization coverage levels.
- ICC and UCI secretariat supported with timely reporting, data analysis and timely required response by the MOH child health team.
- RED strategy implemented in 10 districts and process for expansion to 14 districts established.
- Zambia's immunization performance re- Awarded a total of \$2.865 million for extra children immunized above target.
- The number of un-immunized children reduced from 24,000 in 2003 to 16,000 in 2005.
- Number of high risk districts in Maternal Neonatal Tetanus reduced from 13 in 2003 to 5 in 2005.
- Contributed to the process of Zambia being certified polio free through documentation and attendance to the polio expert committee.
- Provided TA in assessing, planning and training to the 10 out of 15 high risk districts.

- Logistics, transport, human resource requirements and challenges identified in preparation to responding to polio high risk districts.
- Preparation for Emergency and routine immunization strengthening and disease surveillance plan in place for polio high risk districts.

## Lessons Learnt

Fortification while being a public health strategy to control micronutrient malnutrition, will not work if the industry is not engaged from the beginning of the program. The fortification programme in Zambia has been well designed in that the industry has been part to the programme from inception.

The Quality of fortification will depend on the technology available in the industry. Most of it requires some capital outlays.

Mandatory legislation is not possible before the industry is ready to fortify. This therefore means that the sequence of activities needs to follow the sequencing of the fortification process.

The slow pace of the consultation on the GAIN proposal due to GRZ bureaucracy led to the delay in dispersing the funds for fortification. This has caused delays in the commencement of the maize meal fortification programme in Zambia.

The shortage of staff and funds at NFNC has impacted negatively on the fortification programme. There is inadequate monitoring of other fortified foods. Also the addition of Maize meal to the least of fortified foods will be a big challenge to NFNC in that it will require more staff and funds to adequately monitor the fortification process.

The inadequate coordination by government partners of the IMCI programme poses challenges in attaining the desired targets. This in most cases was manifested by meetings or activities that require same staff being conducted simultaneously. The weekly child health working group meetings is a possible solution to provide an integrated forum for all the partners. HSSP will advocate for more partners to attend the weekly meetings. The inadequate staff at national level and districts levels poses a challenge to the quality of service being provided. HSSP strives to help out on all issues pertaining to child health. However, this is not possible at district or community levels.

There is a continued indication of lack of ownership of child health programs such as IMCI, child health week leading to inadequate planning and budgeting by the PHOs/DHMTs leading to partners in most instances being responsible of planning and executing activities even in instances where the government counterparts are available. HSSP will continue interacting with the districts and PHOs in different meetings in order to advocate for ownership of programs.

Most child health programs do not receive the much needed supportive supervision and monitoring in order for the to be effective. This weakens the implementation of

programmes as monitoring assist in strengthening and improving the quality of services being provided. HSSP has planned for the improvement of supervision, monitoring and feedback in the next work plan.

Districts claim that the basket funding from the MOH is inadequate for the implementation of child health activity especially at the community level. They are always requesting for financial support from cooperating partners. This attitude has resulted in inadequate planning and budgeting for child health services by DHMTs. Cooperation among partners is essential for the success of the IMCI implementation. In relation to C-IMCI currently most of the community child health services provided by partners are concentrated in the same few areas.

Inadequate number of Health Centers and health posts coupled with difficulties to carry out comprehensive outreach activities due to inadequate funding and critical shortages of staff has lead to poor implementation of child health programs such as EPI. It was also observed that there was some inconsistency between decentralization principles and funding i.e., direct project and programs, multiplicity of workshops especially at district level, lack of specific initiatives to target the poor EPI performing districts and communities such as among shanty compound residents

### **Way Forward**

In the maize meal fortification there will be enhanced follow ups on the GAIN funds and also assisting the NFNC and MOH to continue sensitizing the millers and other stake holders on the fortification program.

To assist industry in identifying the problems and solutions in the mixing process so as to continue improving the quality of fortified foods. As the millers start fortifying, the legislation should be made mandatory as quickly as possible. Conduct feasibility studies as soon possible to establish other potential food vehicles and develop fortification programmes for them.

Next year should focus on the finalization of comprehensive IMCI preliminary visits to the remaining..... districts in order to scale up comprehensive implementation. The IMCI and C-IMCI strategic plans need to be disseminated to all the PHOs, DHMTs and partners in order for them to buy into them. HSSP should also provide technical assistance to MOH in coming up with a comprehensive monitoring and evaluation tool for IMCI activities. This should also be strengthened by the creation of a database for comprehensive IMCI activities at all levels. More efforts will be put into the strengthening of community level capacity building, C-IMCI implementation and go through the process of operationilizing H/PD. The EPI program will ensure availability of immunization vaccines and related supplies in all the districts and health facilities through the implementation vaccine management techniques. The program will endeavor to run an efficient cold chain system and encourage preventive maintenance of equipment in all the districts to ensure quality of an immunization programme.

To improve immunization coverage the Reach Every District/Child strategy will be used in the high risk and districts with high population of un- immunized children. Integration of immunization services with other child health related interventions will be encouraged for

best results of achieving cost effectiveness. The inclusion of Private Practice in the implementation of immunization services will be cardinal for the success of EPI. To ensure good performance of EPI DHMT's will be encouraged to conduct special mini campaigns for extending a package of immunization for and other priority services in remote areas that lack outreach services.

### **Coordination with other partners**

Coordination with other partners in the implementation of Child Health Week is mainly done through the Child Health Technical consisting of child health working group and NFNC meetings conducted every week on Tuesday at the UCI secretariat. At these meetings partners work together in the various components of planning and implementation of different components of CHW

All the fortification activities are conducted through the NFNC and the National Taskforce on Fortification ( National Fortification Alliance). The Task Force comprises members from different Government Ministries and the food industry. The task force is being strengthened and the name changed to National Fortification Alliance.

HSSP has been communicating with various partners through different means in order to increase the number of collaborating partners. Relationships have been established with representatives from most of the NGOs and Ministries of Agriculture and Education. This step has improved the collaboration as well as mobilisation of funds. Efforts were made to ensure that the partners from relevant agencies were involved in the development of the C-IMCI strategic plans and development of comprehensive IMCI preliminary visit and implementation guidelines

The main stakeholders of the immunization program in Zambia at national level are MOH, CBOH, CHAZ. The main cooperating partners are WHO, UNICEF, USAID/HSSP/HCP, JICA, Rotary International and DANIDA. .

With the high number of partners for immunization, strengthening the coordination role and mechanism by the UCI secretariat becomes instrumental for the implementation of the immunization program in Zambia.

# Reproductive Health Annual Report for Year 1

## Objectives

In the first year (FY01) the HSSP will:

- Support the CBoH to conduct research on home deliveries and identify feasible interventions to increase facility deliveries
- Facilitate a consensus building workshop among nursing and medical councils, MOH, CBoH and others on requirements for expanding the cadre of providers of EmOC
- Support the CBoH to develop cost-effective ways to promote linkage of ANC services with STI, FP, nutrition, malaria, and HIV/AIDS.
- Support the CBoH to promote birth preparedness and complication readiness through partnerships with Neighbourhood Health Committees (NHCs), traditional healers, TBAs, and CBAs
- Work with District Health Management Teams (DHMTs) to establish or strengthen emergency transport and community finance schemes for safe motherhood.
- Support the Provincial Health Offices (PHOs) to conduct bi-annual performance assessments (including integrated reproductive health data analysis) and provide appropriate technical support
- Assist the CBoH to outline strategic plans for key RH initiatives.
- Support the CBoH to revise the FP portion of RH guidelines in line with international standards and to standardize FP training materials
- Work with the CBoH to scale up existing EBA/CBD programs.
- Work with the Behaviour Change Communication (BCC) partners to integrate FP messages into services and messages for Safe Motherhood, STIs, adolescent health, school health, and HIV/AIDS.
- Support the CBoH to establish or strengthen youth-friendly RH services in all districts
- Work with the CBoH to develop STI operational protocols to reduce STI/HIV transmission.
- Collaborate with BCC partners to develop campaigns to increase awareness of STIs and reduce stigma associated with STIs/HIV.

## Overall Strategy

The IRH team will work closely with the CBoH to implement selected interventions that address the objectives listed above. In doing so, the IRH team will collaborate with other HSSP partners (e.g. Human Resource, Drugs and Logistics, Knowledge Management and Systems teams) as well as other development partners. The IRH team will put great priority on supporting the PHOs and DHMTs in IRH strategic planning, implementation and monitoring of activities.

## Challenges

During FY01, the IRH team will expect to face the following challenges:

- Human resource shortages
- HIV/AIDS pandemic
- Irregular supply of drugs, medical consumables and contraceptive commodities
- Poverty resulting in poor nutrition, lack of funds for transportation and for emergency services
- Poor perception of the community about reproductive health issues.

## Implications

Failure to address human resource shortages and motivation in the health sector can adversely affect the implementation of the work plan. Therefore, the IRH team will work closely with the human resource team to find short-term and long-term solutions to this problem. The IRH team will also support all HIV/AIDS prevention, care and support programs that mitigate the problem of HIV/AIDS in Zambia.

The IRH team will also work closely with its drugs and logistic counterparts to ensure continuous availability of essential drugs, medical supplies and contraceptive commodities. The IRH team will also work closely with its BCC partners to educate the community about the adverse consequences of not addressing reproductive health issues.

## Safe motherhood

*Emergency Obstetric Care (EmOC)*

**Strategy: Work with the nursing and medical councils, MoH, CBoH and other private and public stakeholders to develop consensus on strategic questions of skill and training required of an expanded cadre of health workers to provide essential and emergency obstetric care in Zambia**

Though the first activity in the work plan was to get consensus on the expansion of the health Cadre to provide EmOC, it was agreed at the safe motherhood task group meeting that the first activity should be a needs assessment. The other activity planned was to work with the IRH Subcommittee to develop the standardised EmOC curriculum.

Health Services and Systems Programme supported MoH to conduct Safe Motherhood Needs Assessment country wide. Under the leadership of HSSP, a needs assessment plan was developed in conjunction with other stake holders. Data collection tools were adapted and pre-tested under the leadership of HSSP. In addition, HSSP took a leading role in identifying a research team (15) a consultant and statistician (2) from the Central Statistical Office (CSO). The statisticians have played a crucial role in the development of methodology and data entry screen. They will also continue to provide assistance in the analysis of data and report writing. HSSP also hired a project manager to assist with the logistical needs of the needs assessment. Other partners in this activity are UNICEF, and UTH.

A total of about five hundred health facilities including tertiary, provincial, and district hospitals and health centres were covered. The objectives of the needs assessment are:

- To provide CBoH with information on availability of emergency obstetric services
- To provide information on the use emergency obstetric services by women with life threatening complications
- To provide CBoH with information on the quality of the services for emergency obstetric care

Data entry has been completed. With the help of the statistician, data is being analysed. In addition to the above activities, EmOC training materials have been identified ready for adaptation or adoption a workshop to be held soon. Health Services and Systems Programme provided the bulk of technical, financial and logistical support. HSSP is developing a safe motherhood Implementation strategy. The strategy will provide guidance regarding the implementation of the EmOC and Antenatal Care intervention.

**The next steps:**

- Data analysis and report writing,
- Dissemination, planning and implementation of interventions.
- In anticipation of the training needs, HSSP through JHPIEGO has initiated the process of ordering models, equipment and other training materials for EmOC training.
- Meeting to decide on expansion of cadre to be trained to provide EmOC services

**Key Results in Safe Motherhood**

- Needs assessment plan developed
- Data collectors selected and trained
- Needs assessment tools adapted and pre-tested
- Needs assessment completed
- Data entry done now ready for analysis
- Training materials for EmOC identified and ready for adaptation or adoption
- First draft of the safe motherhood strategy ready

*Safe motherhood guidelines* (Pregnancy, Childbirth, Postpartum, and Newborn Care: A guide for essential practice)

**Strategy: Support MoH/CBoH in the development of National protocols/guidelines, training materials, policies and tools for improvement of maternal health services.**

The WHO's Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC) guidelines have been adapted. The document will set the standards for the education of health workers, from medical, nursing and midwifery schools through all levels of paramedical education, as

well as in-service training activities. In addition, the guidelines will provide a guide to Central, Provincial, and District managers to help streamline and strengthen supervision and quality assurance, and will be a guide to facility in-charge and service providers on the standards they are expected to meet.

This followed a process of adaptation including a workshop comprising mostly Obstetrician and Gynaecologists. The workshop was facilitated by HSSP, MOH and WHO consultants. Changes requested at the workshop were incorporated under the leadership of HSSP. The first draft was reviewed by a team of stakeholders and changes were incorporated. The second draft is now ready. A team of two doctors and two midwives has been oriented to the guidelines in readiness for the pre-testing. The MoH is co-funding this activity with HSSP with most of the funding coming from them.

**Next steps:** The pre-testing will be followed by final incorporation of comments (if available), printing and dissemination of the guidelines.

The process has taken long because the soft copy of the document needed special software to effect the changes. Also, it took long to get comments from stakeholders.

#### **Summary of results**

- WHO guidelines adapted and are ready for pre-testing
- A team of two doctor and two midwives oriented to guidelines in readiness for pretesting

#### *Maternal Death Reviews (MDRs)*

**Strategy: Support MoH/CBoH in the development of National protocols/guidelines, training materials, policies and tools for improvement of maternal health services.**

The task for year one was to support CBoH adapt the Maternal Death Review tools. However, more work has been done in this area. Health Services and Systems Programme facilitated the development of the MDR tools. The development of these tools is important because they will assist CBoH to construct the causes of maternal deaths from a health facility to the community. This in turn will help to design more focused interventions. In addition, support was given for pre-testing of the tools and orientation of the districts where piloting will be done (with their respective provinces). The next steps are training of data collectors in the four pilot districts. To this end a workshop to train trainers of data collectors has been done and was fully supported by HSSP. Nine trainers have been trained including six midwives and three doctors. Two of the pilot districts will be supported by HSSP financially. The results of the piloting will be shared at a dissemination workshop. Preliminary work shows that the provinces and districts which were introduced to the initiative are fully in favor of the initiative. This is very important for ownership of the program.

**The next steps:** training of data collectors, piloting of the MDR initiative and dissemination of the results.

### Summary of results

- MDR tools adapted, pre-tested and being used
- Orientation of potential pilot districts with their respective provinces done
- training of trainers of data collectors done and training materials developed

### *Strengthening of Antenatal Care Services*

**Strategy: Work with CBoH/PHOs, to strengthen ANC services and develop cost-effective ways to promote linkage of antenatal services with STI, FP, Nutrition, malaria, and HIV/AIDS services and programs.**

For the first year of the project, HSSP had planned to disseminate the Maternity Counselling Kit (MCK) to health providers in all the districts.

The activities for this area are still in planning phase. This is because the full set of the MCK was not complete and until recently. The MCK was designed to assist the health care provider give focused antenatal care. This will be done through the training of health providers during PMTCT training sessions and through orientation of the MCH coordinators. Another activity in advanced planning stage is holding of Maternal Health Weeks. The objectives of these health weeks will be to provide information on the need for skilled attendant at delivery, danger signs, provision of Antenatal care services, provision of family planning services, and provision of treated mosquito nets. To start with, Central province has been identified. The province has been consulted and is agreeable. National Malaria Control Centre has shown interest to collaborate in this activity. It has not been possible to work with other partners to develop IEC materials for safe motherhood because the lead partner which had committed funds later indicated that it did not have funds. However, HSSP and HCP worked together to produce two programs: Antenatal Care and Birth preparedness for the TV program “your health matters”.

### Next steps

- Collaborate with HCP to determine the extent of support required with a view to co-fund the activity.
- Hold an orientation for the MCH coordinators for all the districts.
- Integrate the orientation to the MCK with the PMTCT training.
- Conduct Maternal Health Weeks.

### **Key Results in Strengthening ANC**

- MCK orientation package integrated into the PMTCT package
- Materials and messages on Focused ANC and Birth preparedness developed and shown on ‘your health matters’ on TV.

*Adaptation of the Road map for accelerated attainment in the reduction of maternal and neonatal mortality and morbidity*

**Strategy: Support MoH/CBoH in the development of National protocols/guidelines, training materials, policies and tools for improvement of maternal health services.**

The task for year one was to support CBoH to adapt the roadmap for accelerated maternal mortality reduction to the Zambian situation and to support CBoH monitor the implementation of the roadmap bi-annually. HSSP provided both technical and financial support for this activity. The road map was adapted and disseminated at a meeting chaired by the Minister of health. The Minister requested the stakeholders to come up with an addendum whose focus would be on interventions that would contribute to the reduction of maternal mortality in the shortest possible time. Four areas were identified including, human resource, equipment and supplies, logistics and community involvement. The document is almost complete. HSSP provided the leadership technically and financially for a series of meetings and consultations. The document is almost ready. What is outstanding is information on the human resource needs. Lack of data in this area has resulted in the delay of its completion. Consequently implementation of the road map has not been done and hence no monitoring of this activity has been done yet.

**Next steps**

- Completion of the addendum to the road map
- Submission to the MoH
- Operationalization of the roadmap

**Summary of the results**

- Adaptation of the Roadmap for accelerated reduction of maternal and neonatal mortality and morbidity done and document available
- Dissemination of the roadmap done
- Draft form of the addendum to the roadmap available

*Postabortion care (PAC)*

**Strategy: Work with the National PAC Task Force to scale up PAC to districts.**

The scale up in Lusaka province started with 3 health centers namely Chilenje, Kalingalinga and Matero and to Kafue district hospital making it a total of 4 sites. In this initial scale up, a total of 27 managers and supervisors were oriented to PAC and 16 health providers underwent MVA standardization training. The 4 sites are now providing quality PAC services and so far 71 PAC clients have been served.

Site	No. PAC clients	No. FP acceptors
Kafue district hospital	44	39
Chilenje health centre	21	14
Kalingalinga health centre	06	04
Matero health centre	0	0

Matero health centre has not yet started providing PAC services because they were still looking for an examination couch for the PAC room. However, they have recently found one and will start providing the service anytime from now.

Site visits were conducted to the other remaining districts in Lusaka province i.e. Chongwe and Luangwa. Luangwa is already providing PAC services under the support of CHAZ but Chongwe is ready for training. Since Mumbwa had indicated readiness to provide PAC services, a site assessment visit was conducted and the district hospital was included for the training as well. Finally the sites which were identified for training were Chongwe, Mumbwa, Chelstone health centre, Chipata health centre and PPAZ clinic making a total of 5 sites. Thirteen managers and supervisors attended the orientation workshop and 10 received MVA standardization training. At the end of the training, the 5 sites were supplied with MVA equipment and are expected to start providing quality PAC services at their respective sites.

The first year target was to cover 10 districts but only 4 districts have been covered in total although the number of established sites (health centres and hospitals) totals 9. Six of these established sites are in Lusaka district alone because of the larger number of health centres in the district and the larger population size compared to other districts. It is anticipated that coverage will be much faster in the 2<sup>nd</sup> year since 2 districts per province will be done in each phase of PAC expansion. In addition, the recently received donation of 300 MVA kits from IPAS (Hewitt Packard Grant) will go a long way to expedite the program. This will result in a scale up of 50 district facilities. Following the experience acquired this year, HSSP is supporting the PAC task force to develop a strategy for the scale up of PAC. First draft is ready and is being reviewed by the Reproductive health technical advisor.

#### **Next steps for PAC:**

In the coming year, 2 districts in each province will be selected for scale up in each phase. This means 18 districts will be covered in one phase and after four phases 72 districts will have been completed. In this way more districts will be covered compared to the previous approach of concentrating on one province at a time. The recently employed PAC coordinator will work with the Task Force to coordinate all the PAC activities nationally

#### **Key Results in PAC**

- PAC orientation for 27 managers and supervisors from Kafue, Chilenje, Kalingalinga and Matero done
- MVA standardization training for 16 health providers from the above 4 sites done
- 71 clients served from the established sites during year 1
- PAC orientation for 13 managers and supervisors from Chongwe, Mumbwa, Chelstone, Chipata and PPAZ done
- MVA standardization training for 10 health providers from the above 5 sites conducted
- 300 MVA kits from secured from IPAS
- Hiring a PAC coordinator done

**Strategy (Safe motherhood) Implement necessary operations research aimed at targeting women who deliver outside of health facilities, to identify feasible and scalable interventions for emergency care during the process of increasing availability and use of home-based life saving skills provided by skilled attendants.**

The IRH team in consultation with the Reproductive health technical advisor agreed that there was no need to conduct an operations research since many studies have been done that have information on why women deliver in homes. It was suggested a desk review be conducted. This was commenced in February 2005 and a final draft of the report is available, but recommendations need to be re-visited possibly at a the dissemination meeting. The main objective was to conduct a research on why women deliver in homes and identify feasible interventions.

The major findings are that women deliver in homes because of:

- Long distance to health facilities
- Poor quality of services including poor infrastructure
- Lack of skilled manpower
- Poor performance and attitude of staff towards patients
- Cultural factors were women think delivering at home is cultural and a good practice
- Lack of knowledge especially on danger signs

#### **Next steps**

- Printing of the document and dissemination

#### **Summary of results.**

- Desk review on home delivery completed and draft report available

#### **Challenges Lessons learned for safe motherhood**

- Availability of space for PAC services – In most centers that were visited there was a problem of identifying space to be used for PAC services. This delayed the establishment of services at the sites. Matero health centre in Lusaka for example took almost 2 months to prepare a room to be used for PAC services.
- Effort should always be made to collaborate with other stakeholders as was the case with HSSP's collaboration with CHAZ which provided MVA kits. The kits run out at the University Teaching hospital.
- Money can be obtained from MoH for activities as shown by their contribution to some of the activities.
- There is a shortage of human resource in the health facilities. This means that there few members of staff to train. Furthermore training of the available staff results in health facilities being left unattended to.
- It is very difficult to get partners to do a task together because they also seem to have their own priorities. As result activities which require their participation takes long to complete.
- Shortage of staff at the Central level also delays execution of programs.

## Family Planning

### *Family Planning guidelines*

#### **Strategy**

**Work with CBOH and other partners to update the FP portion of the Reproductive Health guidelines to bring key service elements (e.g., birth spacing and counseling) in line with current international standards, align in-service and pre service training curricula with the revised guidelines, and train core groups of trainers, faculty, and preceptors in the revisions as well as in expanded methods of long term and permanent contraception (LTPM).**

Three activities were planned, these are: support CBoH to convene a meeting of the FP task group to review and up date the FP policy and guidelines; support CBoH to organize a FP material standardization workshop; and support CBoH to up date FP trainers on the standardized FP materials. The Family planning policy and guidelines has been revised. The document has been finalized and will be handed over to CBoH for endorsement. The standardization of training materials could not be conducted because CBoH wanted work on the policy and guidelines to be done and completed first. This also meant that FP providers could not be oriented. HSSP will support the dissemination of the document. With the development of the Guidelines HSSP will now support the standardization of the family planning training materials. The main Lesson learned is that it is difficult to speed up an activity when it is being spear headed by other partners

#### *Training in long term methods of family planning*

This activity was not planned for in year one. However CBoH requested for to train health providers in long term methods of family planning mainly to avoid the imminent expiration of the Jadelle. Health Services and Systems Programme supported CBoH to establish training teams in each province for long term family planning methods: Jadelle and IUD. The process of training trainers in these methods have been done in conjunction with UTH and the approach is that of a cascade model. HSSP provided financial and technical assistance. The following activities have been conducted:

- Identification of master trainers (9) for Jadelle and IUDs followed by identification of training materials to be used for the trainings.
- Clinical Training Skills were conducted to the master trainers
- Trainers of trainers were conducted for Copper-belt, Lusaka, Southern and Central provinces. A total of 20 health providers were trained.
- The training of the remaining five provinces has not been conducted to date, because Jadelle had run out. At the request of HSSP through CBoH, UNFPA ordered Jadelle. However, the trochars used for the Insertion were not included and these had to be re-ordered.
- It must be mentioned here that when CBoH asked for assistance to train providers for Jadelle, the stocks in the country were expiring in June and training had to be done quickly so that these were used before they expired and they ran out. Therefore even the provinces (Southern and Copper-belt) that were ready to roll out could not do so.

- The running out of Jadelle has affected the results for HSSP. Only four provincial teams have been trained so far. In spite of the problems faced, there has been an uptake of 522 out of the targeted 600 clients for the first year.

The issue at hand is how to ensure that of Jadelle or other contraceptives do not run out. Lobbying for the employment of the logistics person in CBoH/MOH for contraceptives (for which UNFPA has funding) is important

**The next steps include:**

- Phase two training of trainers in the remaining five provinces
- Support to provinces to conduct roll out training for their districts
- Monitor trainers and implementation in the five provinces

**Lessons Learned.**

- You can achieve a lot by collaborating with other partners e.g. we facilitated the procurement of training equipment, Jadelle and the trochars through UNFPA.
- Logistics for supply of contraceptives is weak
- There is need to strengthen the logistics and reporting systems in family planning.
- Regular monitoring of programs will contribute to effective implementation.

*Support to CBoH to orient DHMT MCH coordinators to Depo Provera*

This was not a planned activity. Depo provera was procured by USAID and launched in April 2005 during the World Health Day. However in spite of the launch DHMTs were not ordering the Depo. It was decided together with CBoH to orient all MCH coordinators to Depo. HSSP supported the orientation of 60 MCH coordinators from sixty DHMTs, twelve districts were not represented. The objective was to make the MCH coordinators aware that Depo is available; orient them to Depo since it has not been used for a long time; and to discuss the procurement and reporting on contraceptives. It was also an opportunity to orient them to female condoms, which are plenty in medical stores and are not being ordered. Even in Lusaka Urban, almost all health centres do not have female condoms. During the orientation it was brought out that the report forms that the MCH coordinators receive from their health facilities do not have information on specific methods, instead it just shows them the number of new and continuing acceptors. As such even when they order contraceptive commodities they just use estimations and this contributes to the stock outs or over stocking of contraceptives in health facilities. After discussions it was agreed that the tally sheet from Lusaka Urban and the report form used before the Health reforms be adapted and be used by all health facilities

**The next steps are:**

- Follow up on the registration of Depo Provera
- Work with the Logistics team to facilitate access of the contraceptive when it has been registered

- Follow up on orientation of health center staff by MCH coordinators as planned during the orientation workshop
- Ensure that the issue of reporting formats and the tally sheets are taken care of the revised FP Curriculum

### **Key Results in Family Planning**

- Family planning policy and guidelines revised
- Nine master trainers identified, and trained for IUD and Jadelle Implant.
- Training materials for IUD identified through JHPIEGO and adapted
- Twenty health providers trained as provincial trainers in IUD and Jadelle implant
- Seven Zoë models accessed from JHPIEGO to support provincial Training site for IUD and Jadelle.
- Equipment for IUD and Jadelle training for the 9 provinces procured through UNFPA
- Five hundred and twenty two clients out of 600 targeted for the year, accessed Jadelle implant
- Jadelle and the trochars used for insertion procured through UNFPA
- IUD/Jadelle post training monitoring tools developed
- Sixty MCH coordinators from sixty DHMTs oriented to Depo Provera

#### **Strategy:**

**Build on initial exploration of mobile FP services, just being started under ZIHP, to reach rural areas where there is limited access to a full range of FP methods utilizing JHPIEGO's experience with mobile FP services in countries such as Uganda, Nepal and Haiti.**

The plan in year one was to support CBoH to finalize training materials for EBA/CBD agents that were developed under ZIHP but not adopted by CBoH, and to support training of CBD agents in 29 low Family performing districts ( with new acceptor rate of below 20 – HMIS data 2003-2004). The CBD agents will provide community education on FP and when implementing the mobile services they will play a major role in community mobilization for the services. The training manual has been up-dated and a final copy available. This will be printed and handed over to CBoH for endorsement.

No district has been trained to date; we were advised by our partners to wait until the manual is revised and issues of changes according to the revised FP guidelines incorporated. Support to district trainings will begin in the second year. The mobile FP services initiative will be explored in year two.

All review meetings have been supported by HSSP

#### **The next steps are**

- Printing of the CBD training manual
- Support 10 low Family Planning performing districts to train EBA/CBD agents

- Plan for the mobile FP services

### **Summary of results**

- CBD manual finalised

### **Strategy**

#### **Performance improvement, supervisory, and community support systems to support higher quality family planning services and develop solutions to key constraints**

##### *Family Planning Situation Analysis*

This was not a planned activity, but it was found necessary to conduct in order to provide a baseline for interventions. It is an activity that has been fully supported by HSSP. It was conducted by a consultant and a team of three interns with technical support from the HSSP research team and the HSSP Family Planning focal person. The study covered 25 districts and 135 health facilities. Other partners were involved in the review of the questionnaires. A final draft document is available. It was requested that the report be given to the IRH/ARH specialist at CBoH for review and this has been done.

The main objective was to provide baseline data for increasing family planning method mix with a focus on clinical methods in Zambia.

#### **The key findings are:**

- There is a critical shortage of trained health workers
- All districts offer oral and injectable contraceptives including condoms.
- IUD. Implants and permanent methods are available in the districts at the
- General/district hospital
- The major reason for not providing family planning in some districts is due to religious reasons and the main reason why IUD and Implants are not provided in most health facilities is lack of skills, 96% while lack of equipment accounts for 25%.
- The most popular method is the oral contraceptive (53.8%) followed by the injectables at 46.2%)
- Districts have sometimes run out of contraceptives. The contraceptives that run out Sometimes are oral contraceptives and injectables (28% each). Livingstone district has experienced frequent stock outs of injectables
- Whereas health workers had a positive attitude towards Implants, they had a negative attitude towards IUDs.
- Knowledge of CBD/EBD roles in family planning from all the respondents was high (above 75%)
- Availability of JIK in the facilities visited is 85%, while knowledge on dilution of JIK is 83.3%
- Only two training sites had all equipment for IUD and Jadelle insertion and removal, these were Livingstone general hospital and UTH.

**The next steps** include printing and dissemination

## **Summary of results**

- Research completed and a final draft report available.

## **Adolescent Reproductive Health**

### **Strategy:**

**Collaborate with counterparts to integrate family planning into services and messages for Safe Motherhood, STIs, adolescent health, school health, and prevention, care and treatment of HIV/AIDS, including in private sector and workplace based programs.**

They were four planned activities:

- Work with Behaviour Change Communication (BCC) partners to develop messages for IRH
- Support CBoH to establish or strengthen youth friendly health services in all districts
- Support CBoH to standardize the peer educator curriculum
- Support CBoH in training of youth-friendly IRH providers

The first activity carried out because our major partner who had budgeted for the activity did not fund. HSSP should plan to fund the activity if we have to move forward.

These activities were planned for year one. In the process of searching for what was available in training peer educators, it was discovered that a manual for training peer educators was available with Ministry of Child Youth and Sport and this was developed by a youth consortium representing different partners including the Ministry of Health. However there was no soft copy and HSSP offered to scan and produce a soft copy. What was not available was training materials for health providers on youth friendly services.

Materials to train health providers in youth friendly services were identified and adapted. Orientation of Health Care Providers has been conducted for Lusaka Urban. Twenty-two people were trained 16 from Health centres and 6 from partner organizations. The adapted training materials were also being pre-tested during this training. The tools (registers and report forms) which were being piloted in Lusaka Urban were adapted after some discussions and adjustments. HSSP supported the meeting to adapt training modules, workshop materials and printing of the training modules.

### **The next steps:**

- Meeting with BCC partners at HCP and draw up a plan, then identify a team that can develop the materials, Development and pre-testing of the materials and finally printing
- Finalize training modules
- Development of monitoring tools
- Follow up of the trainees after 3 months
- Roll out to other provinces.

- Employment of an ARH officer

### **Key Results in ARH**

- Orientation modules for training health care providers in youth friendly services adapted and 6 facilitator’s modules and 22 participant’s handouts printed.
- 16 health providers and 6 partners oriented in youth friendly health services in Lusaka Urban
- Soft copy of Family Life Education Manual.

### **Sexually Transmitted Infections (STIs)**

**Strategy: Work with the CBoH and other key partners to strengthen STI operational protocols based on the current Zambian policy guidelines focused on reducing the transmission of HIV.**

In reference to the work plan the only activity that was started is to collaborate with the existing STI working group to review materials and develop operational protocols. This activity started in the last month of the fourth quarter.

The STI working group has had several meetings and the National STI guidelines are being updated. HSSP will provide TA in updating these guidelines. At the last meeting to update guidelines, HSSP initiated the development of the National STI strategic plan and a meeting was called for all stakeholders to consider this suggestion. The STI working group will come up with a draft document for circulation to stakeholders by the end of September 2005.

**The next steps are:**

- Support CBoH to develop the national STI guidelines
- Work with the STI working group to develop the national strategic plan

Although STI work just started recently the lesson learned is that there is lack of coordination between STI working group members from CBoH and those from National AIDS Council (NAC). The two sides conduct activities without informing their counterparts.

### **Key Results in STI**

## Malaria

### Goal:

To reduce the burden of malaria in Zambia

### Purpose

To strengthen capacity of NMCC to coordinate and facilitate scale-up of services through RBM partnerships.

### Objectives/Technical Areas

- Provide malaria advisor and central support to NMCC and assist all aspects of the National RBM efforts.
- Provide technical, logistical and other assistance to the implementation of the ongoing drug transition
- Support NMCP's campaign against malaria in pregnancy.
- Assist continued expansion of distribution of insecticide-treated bed nets and other appropriate vector control measures.
- Provide TA for Reviewing/ developing protocols for appropriate malaria case management

### Approach

The role of USAID support to the National Malaria Control Programme has evolved over the past three years as new resources and partnerships become available. Now in addition to USAID support, there are significant resources from the GFATM round 1 and round 4, the World Bank Booster Fund, and the Bill and Melinda Gates MACEPA program. The malaria programme now has resources for workshops, trainings, meetings and equipment. As detailed in the report below, HSSP is providing *strategic* support in terms of personnel, technical assistance and partnership development, to facilitate and complement, but not to duplicate support from other sources. Of the five technical areas described below, area 3: Malaria in Pregnancy and area 5 Case Management, have near 100% overlap with activities within the HSSP Integrated Reproductive Health and Child Health units respectively. Likewise part of area 2, for the drug transition has a great deal of overlap with the HSSP systems support to drug logistics.

## Technical Area 1: Support NMCC and National RBM Management Systems

### a. Work plan summary and context

There were three basic areas of management support in the 1 work plan: to post project staff at the NMCC to provide technical and management assistance; to facilitate partnerships, in particular through support to the Zambia Malaria Foundation (ZMF) and to provide a direct grant to the NMCC for specific activities.

The NMCC is experiencing a massive scale-up of activities with additional financial support from the GFATM Round 4, World Bank and Gates. At the same time, restructuring of the CBoH/MoH and continued frustrations with tendering and procurement of commodities place a tremendous management burden on NMCC technical staff. Management systems are not as efficient as they could be, and inordinate amounts of time are spent in unproductive meetings and workshops.

### b. Accomplishments and shortfalls

Accomplishments include the completion of the building construction, begun under the BU ARCH project, and support to the strategic planning – especially in the areas of vector control, malaria in pregnancy and programmatic links with HIV/AIDS. HSSP took over from the BU ARCH project in providing technical and core financial support to the Zambia Malaria Foundation (ZMF) who have grown to become a major partner representing NGOs in the planning and implementation of the National Malaria Program. In September '05 ZMF will begin receiving major financial support from the Global Fund Round 4, and later in the year additional funding from the World Bank. Other accomplishments in the work plan include support to information management at the NMCC, including completion of the September '04 follow up baseline survey, expanded use of the internet, and support to two third-year Peace Corps Volunteers, and other interns from Boston University who worked on various projects within the program

While it has been a remarkable year of growth for the NMCC, management systems are severely overstretched. The BU ARCH project began support for improved management system, including and organizational development review from the business consulting firm DCDM. HSSP has tried to carry on from this business review by hiring a Senior Finance and Administration Officer for the NMCC. Applications were solicited, interviews held, but the process has become slowed within the CBoH and the position is not yet filled. There have also been major problems with information management, procurement and logistics that HSSP has not yet been able to ameliorate.

- a. Building construction completed;
- b. Use of Information Communications Technology expanded at NMCC;
- c. Strategic plan and new partnerships with GFATM Round 4, World Bank and MACEPA completed;
- d. Boston University Interns and U.S. Peace Corps Volunteers complete projects;

- e. Follow-up to baseline survey completed and analyzed;
- f. NMCC successfully hosts regional ‘Africa Malaria Day’
- g. Data developed by NMCC used for strategic planning
- h. Zambia Malaria Foundation becomes major RBM partner and now receives financial support from GFATM and World Bank;

### **Key Results in Malaria**

- Completed expansion of NMCC conference, laboratory and office space begun under Boston University/ARCH;
- Participated in proposal development and strategic planning for historic scale-up of investments in Zambia Malaria Control;
- Zambia Malaria Foundation firmly established with GFATM core support and election as one of two global NGO representatives to RBM Board;
- Continued clinical efficacy monitoring and facilitated ACT distribution and training;
- Packet of interventions to reduce burden of malaria in pregnancy (IPT and ITNs) incorporated into Reproductive Health Programs;
- Malaria in Pregnancy communications included in Ministry of Education and other youth-oriented programs;
- Collaboration established with RAPIDS, UNHCR and other organizations for delivery of free ITNs to PLWHA, OVCs, refugees and other vulnerable groups;
- Integrated Vector Management introduced to Zambia; facilitated further USAID support to Indoor Residual Spraying and safe use of pesticides;
- Malaria components of C-IMCI and Facility IMCI expanded through HSSP Child Health Unit, including;
- Outpatient malaria study analysis completed and disseminated;

#### **c. Lessons learned.**

This first year was a transition for USAID-supported malaria activities, moving from a single, independent unit within the NMCC to become part of a larger HSSP team. This led to some communication and collaboration challenges, and a redefining of the project’s role in the malaria program, in relation to the new partners, GFATM, World Bank and MACEPA.

#### **d. The way forward**

As mentioned above, there is currently a great deal of donor interest for malaria control in Zambia. This is, literally, the chance of a lifetime that may never happen again. It is imperative that HSSP does everything it can to help the NMCC effectively plan, implement and monitor these new resources. The Sr. Finance and Admin officer, should greatly relieve management strain at the NMCC and allow the

technical officers to spend more time for implementation. Information Management remains a key concern, and possibly an area of strategic HSSP support.

## **Technical Area 2: Provide technical, logistical and other assistance to the implementation of the ongoing drug transition**

### **a. Work plan summary and context**

There three elements in the work plan for in this second technical area for drug transition, support to the clinical efficacy monitoring, information management and drug logistics, and finally support for a sub regional information network for clinical efficacy.

In 2003 Zambia made a bold step to become the first country in Africa to deploy an Artemisinin-based Combination Therapy (ACT) nation-wide as a first-line drug. By the end of 2004 the ACT Coartem<sup>®</sup> had been delivered to government health facilities on all 72 districts. Coartem<sup>®</sup> deployment represents a very large financial and political investment by the government, WHO, the Global Fund and the manufacturer Novartis.

### **b. accomplishments and shortfalls**

The clinical efficacy monitoring, which had been fully funded by CDC and Boston University in the past, is now receiving funding from GFATM. HSSP was very closely involved with the analysis, dissemination and publication of the earlier clinical efficacy monitoring trials – but did not collaborate closely with the February '05 trials. HSSP is again involved with protocol development for the '06 trials, including for the first time, an evaluation of SP in pregnant women. There have also been numerous other technical inputs for the pharmacovigilance system and discussion of other ACT drugs in addition to Coartem

Despite the central importance of the drug transition, the drug information and logistics system was still very fragile through the year due to staff shortages at the NMCC and the changes at CBoH. Likewise a “pharmacovigilance” system was created but is still rather weak. HSSP has been working actively with partners, with the CBoH, Medical Stores Limited, and the newly created Pharmacy Regulatory Authority to determine exactly how can help strengthen logistics in a way that does not ‘verticalize’ malaria commodities, but provides support to all of the essential medicines.

A third element in the work plan was the development of a sub-regional network for tracking malaria drug resistance, probably to be based at TDRC. Discussions were held, but this activity would require external funding, which has not yet been secured. We are optimistic that with the new MACEPA partnership, we can facilitate some of this cross-border information exchange.

**Results**

- a. Clinical efficacy monitoring trial results analyzed and disseminated;
- b. Facilitated ACT distribution (and accompanied training) to all 72 districts by December '04;
- c. Continued development of drug logistics and pharmacovigilance systems;

**c. Lessons learned**

Coartem<sup>®</sup> is the cornerstone of the Zambia malaria control programme and can not be allowed to fail. Problems in the “supply chain management” have been identified, albeit in some cases a bit late, and remedies are being implemented. As the HSSP Drugs Logistics Officer has often said, logistics are often not given the attention deserved, until there is a problem, and “if there is no product, there is no program”. This is now more clearly understood and we feel optimistic that HSSP will be able to make further contributions to ensuring that the system runs smoothly.

**d. The way forward**

HSSP will continue to provide technical support to clinical efficacy monitoring and pharmacovigilance, including the possibility of providing technical assistance for adverse reactions specifically between anti-malarials and anti-retrovirals. HSSP will also work with partners, UNICEF, WHO, MSH, JSI/Deliver to help with overall improvements in the drug logistics systems, including Coartem<sup>®</sup>.

### Technical Area 3: Support to NMCP's campaign against malaria in pregnancy

#### a) Workplan summary and context

With the development of the RBM 5-year strategic plan, 2006-2011, the HSSP work plan for Malaria in Pregnancy (MiP) was consolidated and refined somewhat. Whereas before, Intermittent Preventive Treatment (IPT), Insecticide Treated Mosquito Nets (ITNs), and links to PMTCT and HIV/Adolescent Health were addressed separately, these have been consolidated to two main activities: supporting MiP components within the Focused Antenatal Care program (for women who are *already* pregnant); and supporting MiP in Safe Motherhood, Adolescent Health and HIV/AIDS/Life Skills programs (for young women and men, *before* they become pregnant. A third area being developed in the work plan for this technical area is to support special monitoring and evaluation needs for Malaria in Pregnancy, including monitoring of anemia as part of the FANC, and support for the Maternal Death Reviews

#### b) Accomplishments and shortfalls

Data from seven sentinel districts reporting in 2004 indicate good uptake of IPT. From a total of 119,969 visits to antenatal clinics, 92,439, or 77% of the encounters included a dose of SP IPT. While the data are being further analyzed the percent of pregnant women receiving at least two doses, the overall summary data is encouraging. Likewise, ITN distribution through direct subsidized sales from the Society for Family Health, and the discount vouchers from NetMark are expanding: the November 2004 NetMark survey indicated an increase in pregnant women sleeping under a net the previous night from 4% in 2000 to 22% in 2004.

Progress in incorporating MiP into Safe Motherhood and Adolescent Health programs has been less clear. Technical support has been given to the NMCC for including MiP into materials for the Ministry of Education, Curriculum Development Committee and for teacher training materials, as well as materials for youth groups, including the Zambia Scouts Association, in all cases linking malaria issues to HIV and Life Skills program for youth.

#### Results

- a. Good uptake of IPT and ITNs for pregnant women
- b. Consolidation of MiP within Reproductive Health activities
- c. MiP included in MoE, and other youth-orientated programs, including HIV/AIDS and life skills programs

#### c) Lessons learned

MiP from almost nothing in 2003 to a large number of women accessing IPT and ITNs during their pregnancy, increased visibility and advocacy within reproductive

health. Nevertheless, MiP, especially in connection with HIV, is a critical issue with far greater opportunities for analysis and intervention.

#### **d) The way forward**

The new RBM strategic plan provides greater clarity for activities, roles and responsibilities for MiP, with the CBoH Reproductive Health Unit now taking the lead. It is envisioned that with the new MACEPA partnership, HSSP will be able to facilitate greater visibility for MiP, and closer collaboration with HIV/AIDS programs.

### **Technical Area 4: Assist continued expansion of distribution of Insecticide-treated mosquito nets and other appropriate vector control measures**

#### **Work plan summary and context**

The first year workplan included the following elements in this technical area: National ITN Policy produced, disseminated and monitored; ITN data-base continue to be updated; training for Integrated Vector Management begun; Employer-based ITN schemes expanded.

Zambia has shown remarkable progress in expanding access to ITNs. From the November '04 NetMark survey, Household ITN coverage doubled from 25% in 2000 to 50% in 2004. This increase has been accomplished through a mix of delivery systems, encouraging commercial sales to those who can afford the full price, developing a series of subsidy programmes for those who can only afford part of the price, and systems through NGOs, home-based care, and social welfare groups for delivering free nets to the most vulnerable, especially Persons Living with HIV/AIDS, and OVCs. Since 2004 two other distribution channels have developed, ITNs for hospital facilities and ITNs for secondary boarding schools. While access to ITNs have been increasing, there is a great disparity between urban and rural populations, and between families in the richest vs. poorest quintile. Likewise there has been an expansion of Indoor Residual Spraying and the introduction of a capacity-building initiative, "Integrated Vector Management" or IVM

#### **b) Accomplishments and shortfalls**

The RBM 5-year Strategic Plan was revised to better reflect needs based on evidence from HMIS and survey results, especially the November '04 NetMark survey. Collaborations were established with organizations, including RAPIDS for the delivery of free ITNs to PLWHA and OVCs. Technical support was provided for the launch of the IVM initiative, for a USAID environmental assessment for the IRS program, and for training and supervision for Indoor Residual Spraying and safe pesticide handling. Support was provided for the successful bid to the 4<sup>th</sup> round of the GFATM to include support to per-service Environmental Health Technologist training and for IVM. Advocacy materials were developed and provided for

employer-based ITN schemes, and protocols develop for the study of malaria economic impact.

Shortfalls relate almost entirely to tendering and procurement problems for ITNs, Insecticides and equipment. Systems are in place to efficiently absorb ITNs when they can become available and to implement the IRS, the problem is timing and delivery of commodities.

**Results**

- a. Expansion of ITN delivery systems to include PLWHA and OVCs
- b. Finalization of ITN strategic plan, including continued targeting, market segmentation and partnerships with commercial sector
- c. Introduction of Integrated Vector Management
- d. Environmental assessment; support to safe and judicious pesticide use

**c) Lessons Learned**

ITN and Vector Control activities are expanding relatively well. Information management is still a challenge that hampers planning and evaluation.

**d) The way forward**

Investments into Prevention activities ITNs, IRS, and IVM will expand tremendously over the next few years. The USG, through the new Presidential Initiative for Malaria will likely increase investment for IRS in Zambia in FY '07. Key areas for USAID 'strategic' support are information management (including mapping), training, and support for the safe and judicious use of pesticides

**Technical Area 5: Provide TA for reviewing and developing protocols for appropriate malaria case management**

**a) Work plan summary and context**

The first year work plan for this technical area includes \_\_\_ areas: support to Community-IMCI; Facility-based IMCI and clinical management training; improved management of in-patient, severe malaria; improved systems for diagnostics; and improved use of anti-malarials in the private sector

**b) Accomplishments and shortfalls**

Closely linked to the second technical area for the drug transition, HSSP, especially the child health unit, plays a central role in improving clinical management of malaria at all levels. The malaria components of C-IMCI and community health worker training was revised. Field assessments were made and strategies are being developed for the provision of ACTs by Community Health Workers.

FY '05 saw the completion of the Coartem roll-out to government facilities in all 72 districts. With financial support from GFATM and Novartis, training on the new drug policy was provided at the central level to at least three persons from every district, and at the provincial level for an additional three or four people from every district. Analysis and dissemination of the BU-supported survey on the management of outpatient malaria was completed, and plans developed for a follow-up survey in January '06

Less progress was made in supporting systems for quality assurance for the management of in-patient, severe malaria, laboratory services and improved use of anti-malarials in the private sector.

#### **Results**

- C-IMCI and Facility IMCI expanded through HSSP Child Health Unit
- Training for ACT used facilitated
- Outpatient malaria study analysis completed and disseminated

#### **c) Lessons Learned**

Quality health services in the community and both public and private health facilities is a major challenge and a focus of almost all we do at HSSP. A challenge specific to malaria is that as systems and services are developed for the HIV pandemic, that these also support development for improved malaria prevention and treatment. In the end, HSSP will be judged by what we have done to help Zambia reduce the burden of both these diseases together, not one or the other, even though the sources of funding to combat the two diseases are different.

#### **d) The way forward**

The posting of the Provincial Clinical Care Specialists offer opportunities to greatly expand support to service delivery, especially for relatively neglected issues of management of severe malaria and laboratory support services. Likewise, recent focus on antimalarials in the private sector will enable the development of partnerships focused not just on the issue of private sales of Coartem, but on the improved quality and use of anti-malarials as a whole.

## **Human Resource**

### **Overview**

One of HSSP goals is to assist the MoH to establish sustainable solutions to curtail the impact of the human resource crisis that has crippled the health sector's ability to provide quality health services to the people of Zambia. This crisis is compounded by the effects of a 16 percent HIV prevalence rate, which has put tremendous pressure on the health sector and is reversing most socio-economic gains made over the past four decades. Scarcity and unequal allocation of human resources for service delivery are among the biggest constraints to extending coverage of MCH, RH and HIV/AIDS services in Zambia. The public sector health workforce in Zambia will continue to decline unless health worker migration to other countries and the private sector as well as the high morbidity and death due to HIV/AIDS are curtailed.

Effective management of human resource issues has been acknowledged as a crucial step towards the success of other health reform goals and interventions to extend coverage of priority services. Resolving the human resource crisis in Zambia requires complex action at the policy, planning, regulatory, legal, management, and training levels. It also requires clarifying disjointed HR management functions currently spread across the Civil Service, Ministry of Finance, and Human Resources Division of the Ministry of Health. Close collaboration is needed with non-governmental stakeholders such as the Medical Council and the GNC.

Finally, it is necessary to address serious morale concerns and the increasing burden on health staff whose performance is affected by HIV/AIDS or the threat of HIV infection. Significant resources are beginning to flow into Zambia to help address the HIV/AIDS crisis, and while the inflow brings much-needed support, it could divert scarce health personnel and systems capacities away from traditional public health services to HIV/AIDS. Without creative solutions, the system will have even less human resources to cope with MCH and RH issues that have major impact on maternal and child morbidity and mortality.

### **Goals/Objectives**

### **General Strategies**

In the first year HSSP planned to do the following:

- Work with the CBoH and other stakeholders to update the 10-year health sector HR plan, using an adaptation of the WHO model for health workforce planning. Take into account recent DHS findings and all factors that affect current supply and demand, including HIV/AIDS, comprehensive changes in the nursing curricula, expanded use of CHWs, and other changes since 2000.

- Conduct an assessment of legal, policy, HR, and labor relations implications of the new government-wide decentralization of the health sector, including position of the civil servants' trade union
- Conduct assessment of the HR implications of public-private partnerships and of health workers who simultaneously practice in the public and private sectors.
- Strengthen the Human Resource Information System (HRIS) by including information on training and skills acquired by health workers and feeding that data into training and sector, PHO and DHMT planning and resource allocation.
- Work with the MOH, CBoH, and Civil Service to develop standards and procedures for rational deployment of human resources to meet the needs of the public service delivery system.
- Provide analytic and implementation support to the HR Emergency Steering Committee established as a result of the mid-term review of the NHSP, including clarification of responsibilities for human resource planning and management.
- Work with the MOH, CBoH, medical and nursing councils, and education and training institutions to review health worker competencies in relation to demands and quality perceptions of the population – focusing on MCH, RH and HIV/AIDS services for these populations – to see if any realignment is needed for HR planning and training purposes; take into account training needs for supervision, HR management and administration, and needs for non-medical staff required to support programs (e.g., logistics specialists, data analysts).
- Provide assistance with a management audit of HR issues and use the results to identify opportunities for improving conditions of service, motivation, and retention of health care workers.
- Provide assistance in evaluating the incentive scheme recently adopted under the SWAp to facilitate replacement of Dutch doctors with Zambian doctors; prepare a review of incentive schemes in the Region and elsewhere to identify lessons for possible adoption.

## **Performance Improvement**

### **Supervision**

- Work with the CBoH and PHOs to strengthen PA skills for integrating quality improvement actions by analyzing data from the routine information systems for health status (HMIS), drugs (Logistic Management Information System - LMIS), human resources (HRIS) and financing (FAMS).
- Develop the requisite operational tools for self-assessments and peer reviews at each level of care.
- Support the development of PA process that is of supportive supervision and self-assessment using operational tools that contain performance standards.
- Work with the CBoH to evaluate other QA and QI systems that have been developed and tried out in Zambia and draw lessons from these experiences, which can be further incorporated into the PA process.

- Develop new performance assessment tools for supervising community-level interventions carried out by CHWs, CBAs and other community providers in malaria, C-IMCI and RH.
- Assist the CBoH with completing a Guide to Quality Improvement to provide operational guidance for Performance Assessments, supportive supervision, self assessments, and provisions of effective technical support and follow-up.

### **Training**

- Work with the MOH, CBoH, medical and nursing councils, and educational institutions to develop a 5 year plan to integrate, coordinate and strengthen pre- and in-service training in MCH, RH, Environmental Health, and HIV/AIDS services in Zambia.
- Develop milestones, results, and a monitoring and evaluating mechanism to track progress and measure impact.
- Work with the CBoH to establish a national coordinating structure responsible for ensuring comprehensive planning and optimal resource use for in-service training, and for setting standards for managing, designing and evaluating in-service training.
- Work with MOH/CBoH, councils and key representatives of the medical, midwifery and nursing schools to put in place a decision-making body or steering committee to periodically review curricula for MCH, RH and HIV/AIDS, recommend changes as needed, and develop standard processes for strengthening pre-service institutions.
- Work with the GNC to monitor educational standards of nursing in training institutions, strengthen curricula for enrolled and registered nurses, standardize technical information, and strengthen clinical practice opportunities.
- Strengthen curricula developed for clinical professions with a focus on the needs of rural health, community communication and problems with stigma and discrimination.
- Work with PHOs to build DHMT's capacity to coordinate and/or conduct in-service training activities as determined by Performance Assessments conducted in their districts.
- Develop training approaches that do not entail group-based or off-site (e.g., through on-the-job training, distance learning, team approaches).

### **PEPFAR Objectives**

In addition to the above generic HR objectives that will support service delivery, HSSP has specific objectives that will directly address PEPFAR targets.

Under PEPFAR the HR first year objectives for planning and management will include:

- Working with MOH Human Resources Task Force to address immediate issues, including updating staffing patterns to reflect current needs and workforce.
- Assessment of human resources management completed, including a review of existing conditions of service for both urban and rural health workers, a survey of

factors contributing to job satisfaction and dissatisfaction and interviews to determine why workers leave the system. This is a necessary first step to develop changes in conditions of service and possible incentive schemes to retain health workers and attract them to critical locations and services (particularly HIV/AIDS).

- Revision of the ten-year human resource plan begun--with special emphasis on improving the analysis of the types, numbers and distribution of health workers needed to provide HIV/AIDS services.

Under National Systems for Planning and Coordinating Training and Supervision of Health Workers, HSSP targets will include:

- Work with MoH to develop a Short-term plan to increase the number of health workers entering the system in critical cadres for HIV/AIDS services developed and implemented.
- HIV/AIDS classroom and clinical training modules and techniques for pre-service training of clinical officers and physicians revised, including updating teaching material and teaching skills, and working with USG COP and other HIV/AIDS service delivery partners to ensure high quality services at clinical practice sites.
- National plan for integrated pre- and in-service training developed in order to obtain maximized efficiency from coordinated curricula, training sites and trainers. Note that other partners, including other USG COP partners, will play a significant role in assisting the GRZ to actually run HIV/AIDS in-service training courses.
- Supervision and performance improvement systems for HIV/AIDS services in place.

### **Approaches**

The HRH team will work closely with MoH to implement selected interventions that address the objectives listed above. In doing so the HRH team will collaborate with other HSSP partners as well as other development partners. The HRH team will put great priority on supporting Medical and nursing councils and training institutions to plan implement and monitor the activities.

### **Activities in Year 1**

#### **Human Resource Planning**

Under HR planning the component support focused mainly on analysis and provision of human resource information to better understand the extent of the human resource crisis. The team worked with the MoH to develop major strategic documents which included the

synopsis paper, High level Forum papers, development and piloting of the human resource ART, PMTCT and CTC planning guidelines for all the 72 districts. In light of the financial and material support from DFID in the development of a human resource database (Payroll Management and Establishment Control – PMEC), HSSP instead provided technical assistance to MoH to identify key HR indicators that would be integrated into HMIS. The indicators would be used to develop HR modules in HMIS. These modules would be used for training human resource and HMIS staff to continuously collect HR information for planning and decision making.

HSSP also provided TA in the development of the HR chapter for the National Health Sector Strategic Plan (NHSP 2006 – 2011). The chapter spells out the critical strategies to address the current HR crisis and boost retention of health workers in the sector. The later part of the year was focused on the development of a costed 5 year plan for Human Resources for Health (HRH). This plan gives the strategic vision for the MoH in their quest to resolve the human resource crisis through comprehensive retention schemes for all health workers. Apart from updating the 2001, 10-year plan, the 5 year plan would be used as the main document for government and donor support to the health sector. The plan has a comprehensive budget that spells out the money needed to implement specific HR objectives.

### **Human Resource Management**

The HR management component, during the first year provided technical assistance for the development of case studies of financial and non-financial incentive schemes in the health sector. The case study was undertaken in Katete, Choma, Lukulu, Sinazongwe, Sesheke, Gwembe, Luwingu, Nchelenge and Chiengi districts. The case studies provided the baseline information for setting up public health sector incentive scheme guidelines for use in the scale up of the Zambia Health Rural Retention scheme for health workers as well as developing strategies to address the HRH crisis. The study also aimed to determine the major motivating factors that look at health workers' job perception and motivation. Lessons learnt from the case study were disseminated to the Provincial Directors and district HR managers in selected provinces. The results of the study will form the basis on which best practices in the management of incentive schemes for health workers can be built. In the later part of the year the HR team conducted a market research to explore appropriate benefit packages for attracting and retaining key skilled health workers in underserved areas including rural areas. The study focused specifically on attraction and retention of Specialists and Nurse Tutors.

Use findings of the market research to develop attractive remuneration packages that will attract and retain identified skilled health workers to areas of need. The results from the market research will form the basis for putting a strategy for curbing attrition and consolidating retention of critical cadres. The results of the two studies both showed that motivation and staff retention is influenced by satisfactory remuneration, a positive work environment and systems that support the worker.

### **Pre-Service Training**

Under the pre service component the HR team worked with MOH/CBOH and other stake holders in setting up teams to develop core competencies for HIV/AIDS service delivery.

HSSP also provided support to MoH/CBoH to conduct an assessment of training institutions for their capacity to produce graduates with knowledge and skills to provide HIV/AIDS services. However with preliminary results showing lack of capacity for training institutions to produce graduates with competence to provide these services it was decided to train faculty and students at the same time. Therefore a short term plan to increase the number of health professionals entering the system with skills to provide HIV/AIDS services was developed. HSSP contributed and participated in the implementation of the short term plan.

Using the National In - service HIV/AIDS training packages, graduating students from 7 health training institutions including School of Medicine have been trained in ART, OI's and PMTCT. To date a total of 26 Seventh year medical students; 44 Sixth year medical students; 18 post basic medical students; 23 medical licentiates; 85 clinical officers; and 147 student nurses. Furthermore 131 faculty staff from training institutions have been trained in ART, OIs and PMTCT to prepare them for the process of curriculum revision and teaching. In addition the knowledge gained will result in improved confidence when teaching the content of the revised curriculum as well as improve quality of HIV/AIDS service delivery by graduates. Work begun on the process of reviewing curricula for Chainama College to incorporate HIV/AIDS core competencies.

### **In-service Training**

In an effort to address In-service training coordination concerns, in year one HSSP provided TA and financial support to MoH to advocate for and develop a National In-service Training Coordination System (NITCS) that spells out strategies, coordination roles and responsibilities at various levels of the health care system. A five year implementation plan was developed and approved. In addition Human Resource Development Committees (HRDCs) have been established at Central, Provincial and District Levels. The role of HRDCs is to review planned training activities at every level and provide guidance on coordination of the training activities. In order to implement the NITCS, HSSP also provided support to MoH to develop National Training Guidelines which 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.

The team also worked with other partners and CBOH to reach consensus on the national training packages for HIV/AIDS health worker training. The team also worked with other partners to adapt Integrated Management of Adult and Adolescent Illness (IMAI) training package in line with WHO guidelines and recommended procedures. The draft IMAI training package is still being edited and finalised by two consultants hired by WHO. In the areas of Support Supervision the HR team worked with Health Systems Planning to provide technical assistance to CBOH in the development of a concept paper for Accreditation of ART services. The concept paper that spells out options of how the accreditation system should be set up and who will be responsible for certification of health workers providing HIV/AIDS services has since been submitted to the Directorate of Clinical Care and Diagnostic services for review.

## **A. Activities not accomplishments**

The following activities were not done and need modifications: -

- The setting up of the Training Information Management System (TIMS) database needs to continue with external technical assistance from the developer.
- The support on development of job descriptions needs to follow the schedule of restructuring of the MoH.
- Finalization of the report on “assessment of training institutions capacity to produce graduates with skills and knowledge to provide HIV/AIDS services” needs to be completed. Follow up will be done with the responsible consultant.
- Finalization and dissemination of competencies document has delayed owing to pressure of work of focal person at CBoH.
- The activity on working with PHOs to build DHMT capacity to conduct and coordinate in-service training using PA results is dependent on the revision of the PA tool which is on-going.
- The exploration of non-group based training approaches should be modified into an operations research activity.

## **B. Lessons Learnt**

The restructuring process of the MoH contributed to the slow pace in the implementation of certain year one activities. We learnt that a number of activities had dependencies on the kind of structure the Ministry was going to take.

## **C. Way forward**

With the restructuring process almost concluded it is expected that most of the activities that had a dependency on this process can implemented within the next year.

## **D. Gender Issues the programme area faces**

In the first year, the HR team did not have activities that specifically looked at gender issues. It is though expected that more gender specific issues will be observed in the later years of the programme when more HR capacity building and training programmes will be implemented.

## **E. Coordination with other partners**

The activities implemented in the first year provide the foundation for establishing effective HR systems. The accomplishments mentioned above have led to a number of stakeholders including the World Bank, European Union, and SIDA to pledge more support to HR activities in the health sector. The increased stakeholders' confidence in the ability of the HR unit continues to provide opportunities for the MoH to attract more funds to strengthen the quality of service delivery. In addition

to being an extra pair of hands, the HSSP technical assistance to MoH human resource unit has enhanced the skills and capacity to effectively and efficiently address the human resource crisis.

## Systems Support

### Policy

#### Background and General Strategies

Major weaknesses in the management of the national health policy cycle and pieces of health legislation by the MoH include:

- Inadequate policy formulation skills;
- Absence of a formal mechanism for tracking the status of implementation of approved health policies and pieces of health legislation;
- Inadequate monitoring and evaluation skills among MoH Policy Analysts; and
- Lack of dissemination of approved national health policies and pieces of health legislation to key stakeholders.

In order to address these weaknesses, the HSSP planned to provide routine technical assistance to the process of formulating and processing proposed national health policies and pieces of health legislation. Other plans included the institutionalization of a mechanism for prioritizing and agreeing each ensuing year's Policy and Legislation Agenda, training of 10 MoH Policy Analysts in basic monitoring and evaluation (M & E) skills and dissemination of selected national health policies, including the National HIV/AIDS/STI/TB Policy.

HSSP's technical assistance approach includes working with the Ministry of Health Policy Directorate, related health sector structures and collaboration with HSSP technical teams such as Reproductive Health, Child Health, Research and Malaria.

#### Accomplishments:

In the area of institutional capacity strengthening for national health policy formulation, HSSP has over the year been providing technical assistance to the MoH Policy Directorate's technical Committees for proposed national health policies. In this regard, support was given to the drafting and editing of the National HIV/AIDS/STI/TB Policy, National Reproductive Health Policy, National Health Research Policy, National Child Health Policy and the National Health Care Financing Policy. During the period under review, the National HIV/AIDS/STI/TB Policy was approved, while the National Reproductive Health Policy was submitted to the Social and Restructuring Committee of Cabinet as part of its preparation for submission to Cabinet for consideration and approval. The rest of the Policies (Health Research, Child Health and Health Care Financing) are in their final draft stages and await stakeholder consensus building before their submission to Cabinet.

Another achievement was the prioritisation and setting of the 2005 MoH Policy and Legislation Agenda and review of the 2004 MoH Policy and Legislation Agenda. HSSP also managed to train 10 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. Following the training, monitoring and evaluation (M&E) indicators were developed by each Chief Policy Analyst for selected national health policies and pieces of health legislation.

HSSP further contributed to strengthening links and communication between the MoH Policy Directorate and the Policy Analysis and Coordination (PAC) Division of Cabinet Office through, *inter alia*, inviting the latter to Policy meetings and training workshops. This was important in light of the hitherto weak links and communication between the MoH Policy Directorate and PAC.

The planned dissemination of selected health policies, including the National HIV/AIDS/STI/TB Policy, was not achieved largely due to work pressures arising from the restructuring of the MoH and other commitments.

### **Key Results of HR**

- National HIV/AIDS/STI/TB Policy approved by Cabinet and disseminated;
- Annual prioritisation and review of MoH health policies and pieces of health legislation institutionalised and documented;
- 10 MoH Policy Analysts further trained in monitoring and evaluation (M & E) skills;
- Monitoring and Evaluation (M & E) Indicators for selected approved national health policies and pieces of health legislation developed;
- Health Research, Child Health and Health Care Financing Policies submitted to Cabinet for consideration and approval; and
- Links and communication between MoH Policy Directorate and Policy Analysis and Coordination (PAC) of Cabinet Office strengthened.

### **Lessons Learnt and Challenges**

One of the major lessons learnt is the need to synchronise HSSP programmatic activities with related MoH programmes/activities. It would appear that, in certain instances, HSSP programmatic activities cannot move at the same pace as those of the MoH with the result that adjustments quite often become unavoidable. To some extent, this is expected as government procedures usually take long.

The other lesson is that policies in the health sector are, at times, subject to sudden and unexpected changes. One example is the change in the dispensation of ARVs from cost-sharing to free access by all those who need them. HSSP should, therefore, be ready to provide the requisite technical assistance as and when requested. In recognising this, the HSSP also should be mindful of the fact that the restructuring of the MoH remains a looming challenge that will impact (positively or negatively) the sequence and pace of its programmes.

### **Way Forward**

The foundation for strengthening the institutional capacity of the MoH in the areas of policy formulation, implementation, monitoring and evaluation, including health legislation, has been set through, *inter alia*, training in monitoring and evaluation skills and backstopping of Technical Committees for proposed national health policies and pieces of health legislation. Consequently, HSSP will build on this foundation by supporting:

- Field monitoring and evaluation of the status of implementation of approved health policies in HIV/AIDS, MCH, IRH, malaria and nutrition;
- The strengthening of the annual Policy and Legislation Agenda setting and review mechanism;
- The submission to Cabinet for consideration and approval of all pending national health policies and pieces of health legislation;
- Further training of Policy Analysts in monitoring, evaluation and other related skills in support of improved tracking of national health policies and pieces of health legislation; and
- The dissemination of approved health policies in HIV/AIDS, MCH, IRH, malaria and nutrition.

In providing this support, HSSP will support the strengthening of links and communication between and among MoH, PAC (Cabinet Office), Cabinet Liaison Officers in other line Ministries, relevant cooperating partners, civil society and the business community (business associations).

## Health Services Planning

### Programme overview

Planning remains the basis through which health institutions (districts, hospitals, and training institutions) receive funding for implementing their health activities. At the start of the project weaknesses were identified in the planning process such as:

- The planning process did not provide adequate guidance to health boards for HIV/AIDS planning; therefore most districts were not effectively planning for and implementing HIV/AIDS activities.
- The Medium Term Expenditure Framework (MTEF) process of planning had just been introduced in the country and most districts as well as the centre did not have much experience in using the process.
- The existing National Health Strategic Plan 2001-05 was coming to an end, therefore it was going to be difficult for health boards to refer to it in the development of the next medium term plans.
- Some of the tools for monitoring performance did not provide for effective monitoring of HIV/AIDS services, therefore there was not enough data for districts to plan for HIV/AIDS activities. while at the same time monitoring implementation of the plans remained weak
- Some districts continued to implement partner activities as opposed to those in their work plans.

### Description of General Strategies

HSSP mandate is to support government efforts for improving quality of life for the Zambian people. To do this HSSP had to work within existing government structures at the Centre, Province and district level building upon what already exists to ensure government goals and objectives are being met. The following strategies were identified and used to address the identified weaknesses:

Work with MoH to strengthen the capacity of the provincial and district level planners in the management of the MTEF process.

Work with MoH to develop multi year planning guidance for HIV/AIDS

Work with MoH to incorporate HIV/AIDS services in the current Performance monitoring & reporting formats and technical guidelines

Provide routine support for the annual planning process

Work with MoH to draft the HIV/AIDS chapter of the 2006-2011 National Health Strategic Plan.

Work with HSSP technical areas in the area planning and quality improvement

## Accomplishments

- To strengthen capacity of District /hospital level planners in multi year planning for HIV/AIDS, HSSP provided technical assistance to the review of existing multi year planning handbooks for five (5) levels (District, 1<sup>st</sup> level hospitals, 2<sup>nd</sup>/3<sup>rd</sup> level hospitals, Training Institutions and Health Centre and Community) to integrate sections for monitoring HIV/AIDS services based on the Basic Health Care Package. At the same time, working with the HIV/AIDS technical area, guidelines on multi year planning for HIV/AIDS were integrated in the same Handbooks. Two additional handbooks were developed for Ministry of Health – headquarters and Statutory Boards, which also incorporated the HIV/AIDS guidelines.
- All 7 planning handbooks have been printed, disseminated to all the relevant institutions and have been used by all the levels to develop their 2006-08 medium term plans. With these inclusions, it is hoped that health boards will have enough data to inform their decisions in what to plan for in the area of HIV/AIDS
- To address the issue of failure by districts to implement their own plans, a format for monitoring implementation was developed and integrated in all the 7 handbooks. With this it is expected that health boards can monitor and report level of implementation and adjust their plans as need arises.
- Support was provided to three staff (two from MOH and one from HSSP) for a study tour in Uganda aimed at strengthening the capacity of MoH to effectively manage and guide district/hospital level planners to the MTEF process.
- Support was given to MOH to draft the HIV/AIDS Chapter for the 2006-2011 NHSP. The chapter which provides approved national strategies for managing HIV/AIDS pandemic will form part of the overall NHSP 2006-2011.
- As part of routine support to the MoH in the area of planning, HSSP provided technical support for the launch of the 2005 annual planning process and finalisation of the health sector plan. The support included:
  - Spearheading the development of National Health priorities for 2006-08 MTEF period, aimed at linking the national priorities from the NHSP and other priorities with the district/hospital level plans
  - Development of Technical programmatic updates for district planning
  - Development of Activity-Based Budget (ABB) data bases for summarising District/hospital, centre & Provincial level plans to make it easier to consolidate the health sector plans in the Ministry of Finance and National Planning (MoFNP) format.
  - Orientation of 6 Provincial Health Officers from each of the 9 provinces, 288 managers from 72 districts, 17 managers from 2<sup>nd</sup> level hospitals, and 44 from 22 training institutions in the new ABB data base use. This will enable them to effectively summarize their medium term plans

- Orientation of districts/hospitals to the revised multi year planning handbooks through the planned district planning launch meetings. The handbooks are now in use in all the institutions
- Contracts for all health boards were revised to assume a generic format and to integrate management indicators. This will enable Ministry of Health to monitor performance of health institutions
- Checklists used to review health institution plans were revised to incorporate new inclusions in the handbooks such as those monitoring for HIV/AIDS services. The checklists will assist to monitor improvements in districts planning for HIV/AIDS activities.

With the above support, all the health institutions have successfully undertaken their planning process for 2005 planning cycle and have signed their contracts with the MoH. This is to reaffirm government commitment to providing technical and financial support for implementation of the health plans.

- As part of HSSP mandate in planning, continuous technical assistance was provided to the National Malaria Coordination Centre (NMCC) for the development of the 5 year National Malaria Strategic Plan. The plan outlines appropriate strategies for management and control of malaria in Zambia. Partners, Health planners at district level and other stakeholders are expected to buy into the Malaria strategy document to develop their malaria activities. The document is expected to be disseminated to all health institutions and will be used as reference document during the planning period annually.
- To ensure effective planning and management of HIV/AIDS patients at all levels of health care delivery systems, the HIV/AIDS Chapter of the Pocket size Integrated Technical Guidelines was revised to integrate guidance on Anti Retroviral Therapy (ART) . The 4,000 copies printed and distributed to all districts are meant for frontline health workers at Health centres level and will be used as quick reference during clinical consultations.
- Due to identified weaknesses in capacity of district/hospital level managers in managing and use of data for planning as has been evidenced from the Action Plans and Contracts objectives and targets, a process to develop a capacity building mechanism has been initiated. The aim is to promote use of data for decision making at district/hospital level, thereby improving the quality of plans.
- Working with Human Resource component, provided technical assistance to CBoH to draft a concept paper on Accreditation for ART services. The concept paper once finalised, will be used by MoH to lobby for support for establishing an ART Accreditation system in Zambia. Follow up activities in this area will be conducted through the HR component.

### **Key Results in Health Services Planning**

- 7 Planning Handbooks
- 4 Health Institution Contracts (District, Church Health Institutions, Statutory Boards & Training Institutions)
- Reviewer's Checklists for district/hospital and Training Institution Plans
- Activity Based Budget data base for districts, hospital and Training Institutions
- Activity Budget Spread Sheets for MoH/Provincial level plan
- 2005 Technical Planning updates
- Summary of National Health Priorities for 2006-08 MTEF Period
- Pocket Size ITGs
- Draft copy of HIV/AIDS Chapter for 2006-2011 NHSP.

### **Activities not implemented**

- The review of the performance Assessment tools to integrate monitoring indicators for HIV/AIDS services has not been implemented due to current restructuring in the MOH. Subsequently, the development of the process for monitoring performance at community level has also not been carried out due to the same problem.
- With the increased demand to monitor quality of care for PLWHAs in ART sites, it is becoming crucial that MoH develops a supervisory checklist that will integrate monitoring of quality of care for PLWHAS.

### **Implications**

CDC planned work with Southern province to strengthen district capacity in monitoring and evaluation as it relates to district planning will require the two projects working together to ensure consistence in information.

The successful development and implementation of the Integrated Supervisory Checklist will help institutions attain expected levels of performance as it pertains to service delivery. Availability of planning guidelines for HIV/AIDS will improve district planning for HIV/AIDS activities

### **Plan for the way forward**

HSSP will provide support to the MOH to: develop technical updates for annual sector planning handbooks; develop a summary of national priorities integrating information on

HIV/AIDS; and help ensure that HIV/AIDS activities, resources and priorities are appropriately reflected in overall health sector plans during the annual planning process.

District and hospital planners need assistance managing, using and making decisions based on information collected through routine systems and other information sources. In collaboration with the MOH, HSSP will strengthen the capacity of 94 district and hospital managers in 72 districts and 22 major hospitals through orientation to basic data management and the development of a data reference manual for use during the planning process.

### **Lessons Learned**

- The restructuring process in the MoH was a major challenge in the area of planning as this meant building a new team which sometimes was very difficult.
- Some planned activities could not be implemented due to conflicting priorities on the on the partner side coupled by the unfinished MoH restructuring process.
- Planning still remains a major challenge in most districts/hospitals due to inadequate capacity by most managers to manage routine data collected through HMIS, PA & Supervisory systems, and health surveys.
- Focussing on HIV/AIDS services has not been well received by partners who feel HIV/AIDS is only a small piece, therefore focussing on one area only is promoting Vertical planning.
- Coordination with other partners within USAID family with vested interest in the same areas of work still remains very crucial.

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

### **Background**

This program covers two technical areas, each with its own milestones and activities. The first area is the support to the national logistics supply chain for ARVs and other HIV-related commodities in the public sector. Logistics activities were not a priority in the Health Reforms agenda, and hence begun in 2000, gaining momentum in 2001. With the introduction of ARVs in the public sector, it has become increasingly apparent for efficient supply chain management systems if ART programs are to be successful. In this regard, HSSP has continued with its support to MoH in strengthening of logistics management systems, and developed initiatives for a Zambian management information logistics system.

The second area is the support to pharmaceutical management and monitoring of drug resistance. The introduction of innovative and affordable ARV combinations has seen an increasing number of patients accessing treatment. However, there are concerns that the widespread use of ARVs could cause the likelihood of drug resistance if there is inappropriate adherence to treatment regimen. To compound this, there is still limited experience with the operational use of ARVs in general, especially in the different developing country settings. Currently in Zambia, there is no national framework for monitoring of ARV drug resistance. It is therefore important that a national framework for monitoring of ARV drug resistance is developed. It is equally important that measures be undertaken not only to guarantee the quality, safety and efficacy of the products but also to ensure proper monitoring of ARV drug resistance. HSSP therefore supported with MoH in the development of a national framework for monitoring of ARV drug resistance. HSSP has also supported the Pharmaceutical Regulatory Authority (PRA) in the start-up activities for the establishment of the National Pharmacovigilance Unit (NPVU).

### **General Strategies**

HSSP has worked within the established structures within MoH. In this regard it has worked with MoH to develop logistics tools to facilitate the establishment of the Zambian logistics management information system and revised reference materials for improvement of rational drug use in health facilities. HSSP has equally worked with the PRA to establish the National Pharmacovigilance Centre, building on the National Malaria Control Centre (NMCC) Pharmacovigilance system initiative for reporting of Coartem adverse drug reactions/events (ADR/Es). Support has also been given to MoH in the development of the national framework for ARV drug resistance monitoring.

### **Focus for the year – October 2004 to September 2005:**

- Work with CBoH to further build capacity of provincial/district logistics focal persons in strengthening logistics management systems for ARVs and other commodities
- Revise the national standard requisition form
- Develop, print and disseminate the Standard Treatment Guideline and Essential Medicines List

- Review and print the Zambia National Formulary
- Develop draft participants LMS/DILSAT Manual
- Finalize draft trainers LMS/DILSAT Manual
- Establish the *Zambian Tracer Drug/Commodity List* including ARV and HIV Test Kit
- Revise Stores and Quantification Manuals
- Finalize, print, launch and disseminate national Guidelines for Donation of Drugs and Commodities
- Finalize, print, launch and disseminate Guidelines for Operationalization of National Pharmacovigilance Unit
- Print Adverse Drug Reaction/Events forms
- Develop, print and disseminate Pharmacovigilance IEC materials
- Finalize national framework for monitoring ARV drug resistance document

### **Accomplishments**

- Worked with CBoH to further build capacity of provincial/district logistics focal persons in strengthening logistics management systems for ARVs and other commodities
- Revised the national standard requisition form
- Developed, printed and disseminated the Standard Treatment Guideline and Essential Medicines List at national and provincial level. The reference books include a chapter on HIV/AIDS
- Reviewed and printed the Zambia National Formulary to include chapter on HIV/AIDS
- Developed draft participants' LMS/DILSAT Manual. Consensus required on revised national standard requisition form
- Finalize draft trainers LMS/DILSAT Manual. Consensus required on revised national standard requisition form
- Consensus meeting held with key stakeholders and the *Zambian Tracer Drug/Commodity List* including ARV and HIV Test Kit established. Prior to the consensus meeting HSSP provided TA and coordinated TWG meetings for:
  - key stake holder mapping for the consensus meeting
  - Identify criteria for identification of draft tracer drugs/commodities
  - Identifying and development of draft tracer drugs/commodities for submission to the main meeting
  - Development of the program for the meeting
  - Coordinating facilitators conducting presentations at the main meeting
- Stores and Quantification Manuals revised and up-dated
- Finalized and printed the national Guidelines for Donation of Drugs and Commodities
- Provided TA to NPVU/HDR TWGs in development of draft harmonized organogram for NPVU/HDR, definition of roles of the different levels of the health

systems and other institutions and provision of ADR/E forms from other countries for comparative purposes

### **Activities not implemented**

- The Guidelines for Donation of Drugs and Commodities not launched due to further review of the Guidelines for Operationalization of National Pharmacovigilance Unit
- Guidelines for Operationalization of National Pharmacovigilance Unit going through further review as it was later recognized that there was need to link/harmonize NPVU systems and structures to those of the HDR
- Adverse Drug Reaction/Event form being further revised in line with the above changes
- Pharmacovigilance IEC materials not developed, printed or disseminated due to implementation of unplanned activities to harmonize NPVU/HDR systems and structures
- Revised standard national requisition form not yet in use, as still waiting for feedback from MoH

### **Key results in Dugs and Logistics**

- Developed LMIS reporting forms. This will facilitate monitoring of the national supply chain by the national and provincial levels to reduce on under stocking and over stocking.
- Established tracer drug list for Zambia to enhance monitoring the supply chain of drugs/commodities for specific programs which will facilitate monitoring
- Built capacity in 24 focal provincial/district teams for improvement of logistics systems at peripheral level
- National framework for HDR monitoring developed to facilitate establishment of structures and systems for monitoring of ARV drug resistance
- Standard Treatment Guidelines and Essential Medicines List document developed to promote rational drug use and selection of drugs that are on the Zambia Medicines List. This will reduce possible cases of poly prescribing and drug resistance
- Zambia National Formulary document to promote rational drug use. This will reduce possible cases of poly prescribing and drug resistance
- Stores and Quantification manuals revised for use by health facilities for improvement of logistics systems
- National Guidelines for Donation of Drugs and Commodities 3000 copies printed. These once launched and disseminated, will help health facilities make informed decisions when receiving donations, by avoiding acceptance of sub-standard or near expiry drugs/commodities and hence reduce congestion in pharmacy stores

- LMS/DILSAT draft manuals (for trainers/participants) developed for use when training health workers in logistics management systems and self-assessment using DILSAT

### **Lessons Learnt**

- The restructuring of the MoH and departure of a key member for studies, made it very difficult to obtain commitment/consensus in the area of drug logistics.
- 
- High attrition rate of trained staff having a negative impact on improvement of logistics systems, as there is usually no hand-over by trained staff before leaving their stations.
- High movement rate of partners to workshops, seminars etc, is becoming a challenge as sometimes partner can be out of the office for six weeks. This in most cases stalls activities for our programs.

### **Challenges**

- Lack of coordination between CPs when working with our partners, which sends conflicting messages to our partners. A case in point is the issue of national requisition form.
- The award of supply management and procurement to JSI/DELIVER for the ARV supply chain poses a challenge in how collaboration will be conducted in terms of sharing of funds and reporting of activities.
- Pace of recruitment of HR to run the NPVU is crucial, as current PRA staff are already overstretched with routine PRA . Lack of a focal person at the NPVU might stall start-up activities to make the Unit functional

### **Implications**

The lack of feedback on the national requisition form has stalled the generation of logistics report to monitor the performance of the national supply chain system and the finalization of the LMS/DILSAT Participants/Trainers Manuals.

### **Way Forward**

- HSSP will continue supporting PRA in revising and printing the Operational Guidelines for NPVU, Adverse Drug Reaction/Events and the finalization of the harmonized organogram. It will also support the national and provincial launches of these documents. In collaboration of with PRA, HSSP will also support the TOT of a focal national Team drawn from the provincial/district level, for building capacity at in Pharmacovigilance activities at peripheral level. Support to development and dissemination of pharmacovigilance IEC materials. HSSP will support identification of other sources of revenue for Pharmacovigilance activities.

- Support will also be given to MoH to finalize the national HDR monitoring framework. Further support will be given towards the process for establishment of the institutional structures for HDR/NPVU.
- HSSP will finalize conducting a rapid pharmaceutical public sector assessment, based on existing documents, limited focus group work, and interviews with stakeholders. The case study being conducted on the current status and recent developments in the pharmaceutical public sector in Zambia – given the impact of health sector reform efforts, the human resources crisis in the public health sector, and the impact of HIV/AIDS – will analyze a complex situation, the recent history of developments in the sector, and the current or planned roles of various key institutional actors, as well as the different perspectives of those actors.

## **Health Management Information Systems**

### **Annual Progress Report**

#### **Technical Area: Health Systems**

### **Health Management Information Systems (HMIS)**

#### **1. Overview of Planned Activities**

In the area of HMIS, one of the HSSP objectives has been to support the Ministry of Health (MOH) in achieving its commitment of scaling up, monitoring and evaluating the antiretroviral therapy (ART) Programme. In order to achieve this, an antiretroviral therapy information system (ART-IS) has been developed. By the end of 2005, Zambia is expected to put 100,000 clients on antiretrovirals (ARVs). ART-IS will help Zambia report on her progress by the end of 2005 regarding putting clients on ARVs.

Generally, the planned activities include:

- Supporting the development of an ART reporting mechanism
- Identifying a local software company for periodic backup support to HMIS
- Supporting the integration of ART-IS into the training curricula for ART
- Supporting the training of facility staff in ART-IS
- Developing an electronic patient management system
- Initiating the revision of the HMIS database to include ART elements
- Supporting the production of an ART Chapter of the HMIS statistical bulletin
- Providing support to the training of Private Facilities in ART Information System
- Undertaking an inventory of the existing PMTCT and VCT indicator basket
- Agreeing on the minimum data requirements for routine reporting at different levels
- Reviewing gaps between parallel reporting structure and HMIS reports
- Rolling out the ART-IS to all public facilities providing ART
- Working with partners to identify indicators to be included in the mainstream HMIS
- Routine support to the production of annual Health Statistical Bulletin for 2004

Under the development of an ART reporting mechanism, ART-IS has been incorporated in the HMIS reporting system. Public facility staff have been trained in ART-IS. An electronic patient management information system has been developed, CAREware, though not yet completed. An ART Chapter has been included in the Health Statistical Bulletin for year 2004. The PMTCT, VCT, and TB minimum data elements or indicators for routine reporting have been agreed upon with other partners.

#### **2. General Strategies**

The strategy of HSSP has been to work within the established structures of MOH and to support the Ministry in implementing its Action Plan. The strategy also involved creating links with other key stakeholders such as ZPCT, CDC, CIRDZ, MSH, and CRS.

### **3. Focus for the first year**

- Support MOH develop an ART reporting mechanism
- Support MOH train Data Management Specialists (DMSs), District Health Information Officers (DHIOs), Hospital Information Officers (HIOs), Clinicians, Pharmacists, and Nurses in ART-IS
- Support MOH develop an electronic patient management system
- Support MOH revise the HMIS database to include ART elements
- Support MOH produce the Health Statistical Bulletin for 2004
- Support MOH undertake an inventory of the existing PMTCT and VCT indicator basket
- Support MOH roll out the ART-IS to all public facilities providing ART
- Support MOH receive ART reports from the private health facilities

### **4. Challenges**

There are so many players in the area of ART with different and at times similar interests. The other challenge has been to work with the counterparts at CBOH to implement activities planned at HSSP while they are also needed by other partners or players. In some instances, work could not proceed or had to be rescheduled because the counterparts were not available at the time we needed them. The provision of TA to MOH that focuses only on HIV/AIDS has restricted our competences in the area of HMIS.

### **5. Implications**

CBOH called for the harmonization of ART data collection and reporting tools so as to lessen the duplication of work by health facility staff, and to have standardized tools that every partner should be using in the area of ART. The unavailability of counterparts has meant rescheduling activities to later dates. TA is restricted to HIV/AIDS leaving out other issues of equal importance in the area of HMIS.

With the restructuring of MOH, it is hoped that HSSP will continue to work within the MOH structures and implement activities that are of high priority to the ministry so as to remain relevant.

### **6. Accomplishments**

#### **a. ART Information System (Paper Based)**

A paper-based ART-IS has been developed in all public health facilities providing ART. All facilities are expected to report through the HMIS and Zambia is going to report her progress regarding her contribution to the 3 by 5 global target. ART-IS acts as a tracking mechanism in the area of HIV/AIDS. Data collection and reporting tools have been developed and include the HIV Care/ART Cards,

Aggregation Forms (Facility Quarterly, District Quarterly, District Annual), Tally Sheets (Pre-ART & ART Monthly Tally Sheets), Registers (Pre-ART & ART Monthly Registers), and the History, Physical Examination and Eligibility Forms.

**b. ART Information System (Electronic Based)**

CAREWare software has been developed to be used by facilities which have the technical capabilities.

**c. Capacity Building**

The MOH has a national team of ART-IS trainers that can conduct training at any level (National, Provincial, or District). All DMSs and DHIOs, and HIOs, Clinicians, Pharmacists, and Nurses in public health facilities and some mission hospitals have been trained in ART-IS

**d. Standardized ART-IS Training**

Training in ART-IS has been standardized in that the training materials have been developed. A full training package include the following:

- The ART Procedures Manual which explains in detail all the data collection and reporting tools, how to fill them, when and by who. It also gives the general back ground to the ART
- The ART Indicators Manual shows the minimum standard indicators and how they are calculated
- The ART Facilitator's Guide explains how the training should be conducted. It explains what to say, areas to emphasize, the slides to show and when to show them step by step.
- The ART Facilitator's Workbook gives the answers to the exercises and tests given to the participants
- The ART Participant's Workbook has exercises that participants are expected to do during the training
- The Participant's Notes is a book with slides in handout format to assist the participant follow training easily and be able to make notes on slides as they are being shown by the facilitator
- Slides/transparencies – overheads that are used during training have been developed

#### **e. ART Chapter**

An ART Chapter has been incorporated in the 2004 Health Statistical Bulletin

### **7. Deliverables**

- Training Package (This are listed in 6d)
- Data Collection and Reporting Tools (Data Collection Tools include: HIV Care/ART Card; Pre-ART Register & ART Monthly Register; the History, Physical Examination and Eligibility Form; and the Pre-ART Tally Sheet & the ART Monthly Tally Sheet while the Reporting Tools include the Facility Quarterly, District Quarterly, and the District Annual Aggregation Forms)
- ART-IS Software (CAREWare)
- 2004 Annual Health Statistical Bulletin
- Formation of the ART-IS National Trainer of Trainers (21 Members)
- District Training in ART-IS (86 Participants)
- Facility training in ART-IS (344 Participants)

### **8. Activities not Implemented**

- The electronic patient management system (CAREWare) has not been implemented as expected due to reasons beyond HSSP's control.
- The HMIS database has not been revised yet to include ART elements because the HMIS was/is being reviewed, thus, this activity had to wait.
- The private health facilities have not yet been incorporated in the ART-IS because training for public facility staff delayed. In addition, a training mechanism for private facilities is yet to be agreed upon.

### **9. Key Lesson Learnt**

Planning and implementation of activities must always involve the MOH counterparts and other stakeholders.

### **10. The Way Forward**

HSSP will support the roll out of ART-IS to all MOH-recognized private ART Centers so that at least 85% of the facilities report through HMIS. HSSP will support rolling out the electronic patient record system to all public ART sites with capacity and ensure that at least 90% of all public hospitals use the soft ware.

HSSP will support the revision of the existing HMIS data collection and reporting tools to integrate VCT, PMTCT and TB and to train at least 80 (users) province/district staff in the new tools.

It has been observed that the annual health statistical bulletin does not contain detailed information at District Level worse still at Facility Level. Plans are underway to develop a template to produce detailed Provincial Reports. HSSP will support the production of annual provincial health statistical reports so as to assess the ART program at Provincial Level effectively

## **Health Care Financing**

### **Overview of Planned Activities**

Health financing of ART services has had three technical areas, each with its own activities and goals. In the area of ART Financing, the HSSP objectives have been to support GRZ in achieving its commitment of providing ARV to 100,000 clients by the end of 2005, according to the Emergency Plan's (PEPFAR) 2x7x10 goals and the WHO's 3x5 goals. In order to do this there is need to have adequate resources for the provision of this service, most of which has been funded through the global initiatives such as the Emergency Plan, the Global Fund, DFID and other bilateral partners.

In the area of Cost Sharing of ART, GRZ has been making efforts at establishing sustainable policies for supporting the financing of health services. Currently, patients are made to cost-share on ARV by making a contribution of K40,000 and various other fees for other health care services. However, a lot of issues have arisen given the high poverty levels in the country and the need to ensure equitable access to ARV for all Zambians and general health care services.

In the area of ART Social Security Schemes, the work involved the development of social security schemes that will ensure access to ARV for all Zambians who need it, assure continuity of care and minimize events of developing resistance in those taking ARV that might arise due to lack of money to pay for ARVs.

### **General Strategies**

The strategy of HSSP has been two pronged: to work within the established structures of MOH and to support the Ministry in implementing its Action Plan.

This has necessitated the implementation of all activities considered high priority by MOH and in some cases, it has meant diverting away from the strict HSSP line of activities in order to enhance rapport with our counterparts, ensure ownership of the products and indeed the sustainability of the working relationship between ourselves and MOH. The tracking of HIV/AIDS is an example of this experience.

While HSSP focus had been to develop an HIV/AIDS Funds Tracking Mechanism for the health sector, the counter parts had a different view as they did not view this as high priority. While they agreed with the need for a tracking mechanism, they preferred a more comprehensive mechanism which would capture data on all funding sources and amounts of funding to all health programs and not just HIV/AIDS. Funding was therefore solicited from DANIDA and the District Accounting System was developed in place of the HIV/AIDS Funds Tracking Mechanism. HSSP continued to provide support to this process and in the end, the DAS was changed to include a page for tracking funding to all health programs including HIV/AIDS, Malaria, TB, Diarrhoea, Sanitation, Safe Motherhood and other high priority health programs.

A similar experience is recorded in the area of ART Cost Sharing, where previously, HSSP had been supporting the implementation of ART Cost Sharing Operational Guidelines and had to switch course once the policy change was made through the statement issued on June 13, 2005, by the Minister of Health instructing all government health facilities to provide ARVs free of charge to all Zambians who need it. This indeed did alter the relevance of the ART Operational Guidelines which had been previously published.

### **Accomplishments**

- A District Accounting System has since been developed as a tool for recording funding flows to the district health system in all 72 districts. Implemented only in July, 2005, it has been found to have serious flaws in its design and must be re-designed. Currently it is on a trial run for 6 months to assess all the bugs in it; before it is redesigned. HSSP will support the review of the DAS and its re-design and further implementation.
- HSSP further supported the orientation of 9 financial specialists in the DAS and these will provide technical support to the districts.
- In addition to this, a CBOH/MOH Financial Management Manual has been developed for the Center as a tool for managing all resources including financial and physical assets at the Center. The manual awaits the complete dissolution of CBOH before amendments can be made prior to printing.
- Free ARV guidelines have since been prepared, produced and distributed to all government facilities in keeping with the new policy stance.
- A concept paper outlining the existing framework for ARV provision in both the private and public sectors and advocating for the development of social security schemes has been developed.
- Follow-on work has included the three (3) consensus building meetings that have been held to agree on content of the research to be done and the methodology to use. Consensus has been built and this was important before work could begin.
- Compiled literature to be used during the literature review of the social health insurance research.
- A research proposal for the social health insurance scheme has been developed and will be used for conducting the remaining work.
- The CHEWS evaluation has been done and a report been prepared and is under review. The findings of the CHEWS will be used to feed into the process of developing the social health insurance.

- A waiver and reimbursement mechanism has been developed and demonstrated to work for improving access to care for the vulnerable groups including women and children and this will feed into policy making for enhancing access to care for the vulnerable groups. The reimbursement mechanism developed during the pilot can provide input into the development of the organizational structure of the Social Health Insurance Schemes.
- The acceptance and general conduct of the health providers with respect to the beneficiaries under the CHEWS pilot will also provide lessons learnt to the process of using social health insurance.
- A total of 85 district staff have been trained in the Financing of Non Financial Managers course. The course builds capacity in district staff to better manage the financial and other district resources as well as the implementation of the District Accounting System, which tracks HIV/AIDS funds.

### **Activities not Implemented**

- The HIV/AIDS Funds Tracking Mechanism has not been implemented because of its narrow focus on HIV funds along. Instead a more comprehensive District Accounting System has been developed in its place to capture financial data on all priority health programs.
- Monitoring of financial flows into the sector has not been done because the DAS system had to be developed first and be put on a trial run.
- The Financial Analysis of ART requirements has not been done either because the DAS had to be implemented first before the reports could be generated from which to conduct the analysis.
- The field work on the social health insurance could not be done prior to consensus building and the development of a research proposal.
- A Baseline study on access to free ARVs in the districts along the line of rail has not been done in order to allow for districts to adjust to the new policy change. The hypothesis is that: Recruitment and therefore utilization has gone up now that ARVs are being given free of charge at all government facilities.
- The assessment of Exemption mechanism could not be done due to the policy change which has rendered this work irrelevant; following the Free ARV policy change.

### **Key Lesson Learnt**

- We must continue to work within the MOH structures and implement activities that are of high priority to the ministry in order to remain relevant. HSSP must never move

away from its mandate of supporting the health sector to achieve its goals of improving the health status of Zambians, and this requires a holistic approach to the interventions.

## Key Results in Health Finance

### The Way Forward

#### *Social Health Insurance*

- Disseminate the CHEWS Findings
- Field work – Survey of 2,000 Households in Lusaka and Copperbelt provinces.
- Travel to Tanzania and Ghana to collect data on implementation experiences in the countries and draw lessons learnt.
- Fieldwork among the business houses. Carry out interviews with the insurance companies, Private health providers and hospital Executive Directors.
- Conclude the literature review of health insurance coverage and experiences in Sub-Saharan Africa.

#### *Refinement to ART Cost Sharing Policy*

- Disseminate the Free ARV Guidelines
- Conduct a Baseline study on access to free ARVs in the districts along the line of rail. Collect data on utilization rates prior to June 13 and after that date. The hypothesis is that: Recruitment and therefore utilization has gone up now that ARVs are being given free of charge at all government facilities.

#### *Tracking Mechanism.*

- Conduct site visits to assess the implementation of the District Accounting System and provide TA. This will also afford the opportunity for data collection and lessons learnt which will then be used during the redesign of the data base into Access software package.
- Re-design the DAS and re introduce in all 72 districts.

## **HIV/AIDS Service Delivery Coordination**

### **Introduction**

Expansion of programs to respond to growing HIV/AIDS epidemic and increased commitment and support from Government, stakeholders and global initiatives have contributed to the complexities of combating HIV/AIDS in Zambia. As a result of the increased prevalence of HIV/AIDS, at 16% in the age group 15-49 years, inadequate resources and the need to seek solutions to address this, Zambia was considered as a beneficiary to various Global Initiatives such as Global Fund, PEPFAR, ZANARA and WHO 3x5 initiative.

In 2002 The Government of Zambia made a policy decision to introduce ART in the public health facilities and challenged it self to place 100, 000 patients on ART by the end of 2005.

The National Health Strategic Plan which also outlines the objectives and strategies for HIV/AIDS comes to an end in 2005 and a new one, which will articulate the way forward in HIV/AIDS control for the next five years, requires to be developed. The Basic Health Care Package (BHCP) has been in developmental stage since 1996. The HIV/AIDS chapter within the draft BHCP did not reflect the emerging issues such as the ART, PMTCT and CTC services.

In view of this, HSSP supported the Ministry of Health to strengthen systems and coordination of HIV/AIDS services, which will enable sustainable scale up of services. Activities for year one were carried over from the nine month consultancy done under the ZIHP/PHRplus program for the Emergency Plan, whose focus was strengthening the HMIS to track ART patients, development and implementation of ART co-financing and strengthening planning and management of human resources.

### **Objectives**

1. To achieve and maintain high coverage of key HIV and AIDS interventions in the country
2. To maximize the use of resources to strengthen health systems and maintain the key linkages between national and implementing levels as well as HIV/AIDS and other diseases that interact with it.

### **Implementation Strategy**

In ensuring coordination of the HIV/AIDS program, HSSP has been operating through existing health systems, structures and resources at central, provincial and district levels. The project has created functional links with the Ministry of Health, USG partners such as ZPCT, CDC, CRS, CHAZ, Share, other stakeholders and within the project. Monthly meetings have been initiated with partners such as ZPCT, HCP to enhance HIV/AIDS service coordination.

## **Planned activities for year one (October 2004 – September 2005)**

- Support the development of the National Health strategic Plan 2006-2011, with particular emphasis on the HIV/AIDS chapter.
- Facilitate discussions between the Ministry of Health, National AIDS Council, donors and other stakeholders to improve coordination of resources and programs for HIV/AIDS.
- Support the Ministry of Health revise the Basic Health Care Package to reflect current, emerging and planned HIV/AIDS services.
- Provision of Technical Assistance to the Ministry of Health and Central Board of Health through coordination and implementation of the National Antiretroviral Therapy (ART) Implementation Plan.
- Support mobilization of resources both local and international for the ART program.

In order to accomplish these activities, 3 milestones were formulated:

- Support MOH/CBOH coordinate the National ART program Implementation
- Support MOH/CBOH develop HIV/AIDS Chapters in the BHCP and the NHSP 2006-11
- Support mobilization of resources for ART and other HIV/AIDS services for scale up.

## **Accomplishments**

### **Milestone: Support MOH/CBOH coordinate the National ART program Implementation**

#### *The National ART Implementation Plan 2004-2005*

HSSP has supported the printing of 150 copies of the national ART implementation plan. The plan provides a guide to the Zambia ART scale-up program, whose aim is to reduce HIV-related morbidity and mortality through universal access to antiretroviral therapy for people living with advanced HIV infection so as to reduce the socio-economic impact of HIV/AIDS. The printed copies will be distributed to all the DHMTs, PHOs and stakeholders involved in the ART implementation. Only 150 copies were printed because the plan is due for a review in December, 2005. HSSP has also supported the dissemination of the ART plan to all the stakeholders. This has enabled the stakeholders plan their ART implementation according to the national plan.

#### *Operational guidelines for Free ART*

In June 2005, the Ministry of Health made a pronouncement that the Government of the Republic of Zambia will be providing free ART in all public institutions. In view of this HSSP supported the Ministry of Health to develop the guidelines which defined the constitution of free ART. The guidelines have since been approved, 500 copies printed and are currently being distributed to all facilities offering ART.

### *ART partners' database*

HSSP has supported the development of the ART partners' database. The ART database has been designed. The database will enable the Ministry of Health coordinate the ART program. The target for information collection will be all partners involved in the ART program. The database will be updated bi-annually. The database is currently being reviewed by CBOH.

### *National AIDS Council (NAC) Treatment, Care & Support TWG*

HSSP offers technical support to Treatment, Care and Support technical working group, which is an advisory body for the NAC. In quarter four, technical assistance was provided through meetings at which technical guidelines for Treatment, Care and Support were discussed and shared with all ART sites in the country. The action plan for the TWG for 2006 was developed.

### *Provincial Health Office (PHO) Clinical Care Specialists (CCS)*

HSSP has recruited nine CCSs for the PHOs. These Clinical Care Specialists will continue to play a pivotal role in ART coordination and quality improvement. They will provide technical backstopping and supervision to junior medical doctors implementing ART activities in their respective provinces. The HIV/AIDS technical area coordinated the recruitment process and orientation of the CCSs. All CCSs apart from one will have reported to their stations by October 1.

## **Milestone: Support MOH/CBOH develop HIV/AIDS Chapters in the BHCP and the NHSP 2006-11**

### *HIV/AIDS Chapter in the National Health Strategic Plan*

The National Health Strategic Plan 2001/2005 comes to an end in December 2005. HSSP developed an HIV/AIDS chapter which was discussed with stakeholders and included in the NHSP 2006-11.

### *HIV/AIDS chapter for the Basic Health Care Package*

The Ministry of Health is finalizing the development of the minimum package of care for all levels of health care delivery in Zambia. The draft BHCP did not reflect the emerging HIV/AIDS issues such as ART, PMTCT and CTC, hence the decision to revise it. The HIV/AIDS chapter has been developed. In addition chapters on renal, cardiovascular and cancer diseases have also been written upon request from the Ministry for Health. This will enable the Ministry of Health to finalize the review of the BHCP which defines essential services according to the level of care. The review of the BHCP will be coordinated through the Ministry of Health.

**Milestone: Support mobilization of resources for ART and other HIV/AIDS services for scale up.**

Zambia is a recipient of the Global Funds for AIDS, TB and Malaria (GFATM). HSSP supported the Ministry of Health in developing the work plan for Round one continued Phase through technical assistance and financial support for the 2 consultants. The project also assisted to develop the progress reports for Phase one. In addition support was provided through facilitation and provision of strategic direction to all recipients of the Global Fund, namely CBOH, ZNAN, CHAZ and MOF. The funds for this phase were approved and are already being accessed.

**Internal Collaboration**

HIV/AIDS is a cross cutting issue which has led the team to collaborate internally with HMIS, Health Services Planning, Human Resources, Drugs and Logistics, Health Financing. Some of the major areas of collaboration have been, inclusion of HIV/AIDS Chapters in 7 planning Handbooks, development and dissemination of the guidelines for free ARVs, harmonization of M&E for HIV/AIDS, development of the HIV Drug Resistance monitoring framework and human resource crisis papers in Zambia.

**Key Results in HIV/AIDS Coordination**

- National ART Implementation Plan – 150 copies printed
- Operational Guidelines for Free ART – 500 copies printed
- ART Partners Database designed
- National AIDS Council (NAC) Treatment, Care & Support TWG action plan developed.
- 9 Clinical Care Specialists recruited and 7 placed in the provinces
- HIV/AIDS Chapter in the National Health Strategic Plan
- HIV/AIDS chapter for the Basic Health Care Package
- Global Fund Round Five Proposal

**Lessons learnt**

Implementation of HIV/AIDS program activities will guarantee an effective management and coordination of HIV/AIDS services in the Ministry of Health, HSSP, US projects and other stakeholders. This will ultimately contribute to quality and improved health systems for HIV/AIDS services for the majority of Zambians. The ART guidelines are in place and will guide the scale up of ART in the country. The ART database, which has been designed, will assist the government to coordinate the ART service provision by various partners.

Timely implementation of the planned activities was constrained by the limited human resources in the Central Board of Health. There is only one specialist to provide technical decisions and way forward for most of the planned activities.

### **Focus for the next year**

HSSP will continue to assist the MOH to strengthen coordination for HIV/AIDS service delivery with the private sector and with USG partners such as ZPCT, CRS/AIDSRelief, CIDRZ, and Health Communication Partnerships (HCP). Activities will include: providing technical assistance to the Sector Wide Approach program (SWAp) to ensure integration of HIV/AIDS; providing logistical support for overall ART program coordination in the health sector; ensuring responsiveness to emerging issues such as changes in ART policy and implementation guidelines; developing MOH proposals to global HIV/AIDS initiatives targeted at ART scale up; and maintaining partners' database for HIV/AIDS service delivery. In collaboration with the MOH and other partners such as ZPCT, HSSP will also support the development of referral system procedures for public and private sector delivery of ART to help assess the financial implications and flow of services arising from new MOH policies. HSSP will conduct an assessment of the current referral system to identify gaps and define strategies to address them.

## **Knowledge Management**

### **Overview**

Knowledge Management (KM) consists of two components i.e. research and program monitoring and evaluation. The main responsibility for KM is to provide management with evidence based information for planning and decision making. To support Ministry of health (MoH) develop evidence based policies and programmes. Other responsibilities include coordinating research, program planning, reporting and documentation.

### **Monitoring and Evaluation**

#### **Overview of Planned Activities**

Focus in year one was on the following:

- Develop a Monitoring and Evaluation Plan for the program
- Coordinate development of work plans and project reports ( tracking progress reports)
- Develop project reporting formats
- Develop a project data base
- Develop a project website and intranet

### **Progress**

The project Monitoring and evaluation plan was developed, including indicators. Further work was done to conduct a baseline survey for the project. A subcontract for the work was awarded to MLeMba and Associates and preparatory work for field work is expected to be completed in readiness for field work scheduled to commence during the last week of October.

Much time was spent to coordinate development of the project work plans and quarterly reports. The PEPFAR FY06 workplan was finalised and submitted to USAID. HSSP is now finalizing the Yr 2 workplan for the overall program.

Project reporting formats to help track progress were developed, testing, modified. These tools will be included in the data base for efficient project tracking.

Two subcontracts have been awarded, one for development of a data base and another for the Website and Intranet for the project. It was realized that there was need to track progress and report/ share information in a systematic way. Hence these systems will address this challenge.

## **Challenges**

Lack of management procedures has made planning and reporting unduly time consuming. Planning of activities did not allocate time for reporting and related activities and hence it has been challenging to finalise reports in timely manner in the midst of competing demands. The quality of reports has also been affected by pressure to meet deadlines.

## **Way forward**

Efforts in FY 06 will concentrate on finalizing the Baseline survey; Data base and website development. The team knowledge management team will work with management to ensure that planning and reporting are allocated the due time. The quality of the reports also needs to improve with stabilization of the project.